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## PROVINCE OF ONTARIO

*Commission and Committee of Inquiry*

### THE MEDICAL SERVICES INSURANCE ENQUIRY

Proceedings of the Public Hearings  
held at the Galbraith Building,  
University of Toronto,  
Toronto, Ontario, at 10:00 a.m.  
on Wednesday, January 8th, 1964. .

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DATE

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INDEX OF SUBMISSIONS

Page No.

THE OPTOMETRICAL ASSOCIATION OF ONTARIO and  
THE COLLEGE OF OPTOMETRISTS OF ONTARIO

Apparatus: Mr. D. H. L. Lamont, D.C.O.

Mr. M. A. Langer

Mr. T. Baker

Mr. E. T. Attridge

Mr. J. Duffy

Mr. R. J. Broad

DR. J. W. McILLIVRAY

MEMBERS OF ENQUIRY:

Dr. J. GERALD HAGRY

Chairman

Mrs. J. A. AYLEN

Mr. A. ROY COULTER

Dr. R. L. MALLOWAY

Dr. JOHN HAMILTON

Mr. W. S. MAJOR

Miss HELEN McARTHUR

Mr. P. J. MULROONEY

Mr. GARMAN A. NAYLOR

Mr. HARRY SIMON

Mr. J. L. A. WHITNEY

Mr. L. E. TURNER

Secretary



INDEX OF SUBMISSIONS

Page No.

THE OPTOMETRICAL ASSOCIATION OF ONTARIO and  
THE COLLEGE OF OPTOMETRISTS OF ONTARIO

522

Appearances: Mr. D.H.L. Lamont, Q.C.  
Mr. M.A. Langer  
Mr. I. Baker  
Mr. E.F. Attridge  
Mr. J. Duffy  
Mr. R.J. Broad

DR. J.W. McGILLIVRAY

593

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1 ---On resuming at 1 PROVINCE OF ONTARIO

2 MEDICAL SERVICES INSURANCE ENQUIRY

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4 THE OPTOMETRICAL ASSOCIATION OF ONTARIO and

5 THE COLLEGE OF OPTOMETRISTS OF ONTARIO

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9 Ontario, at 10:00 a.m. on Wednesday,

10 January 8th, 1964. Mr. E. P. Attridge

11 Mr. J. Duffy

12 Mr. R. J. Broad

13 MEMBERS OF ENQUIRY: CHAIRMAN: Ladies and gentlemen, I assume

14 this is the Dr. J. GERALD HAGEY optometr-- Chairman

15 Mrs. J.A. AYLEN the instructions on the table

16 before you? Dr. WILLIAM BUTT

17 Miss HELEN CARPENTER an who wishes to introduce

18 your delegat Mr. DALTON J. CASWELL the part of the

19 Mr. A. ROY COULTER Chairman and ladies and gentle

20 men, may I s Dr. R.J. GALLOWAY duction for our delegation

21 representing Dr. JOHN HAMILTON optometry. That is the main

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24 body from On Mr. P.J. MULROONEY ising optometrists, and the

25 other brief Mr. CARMAN A. NAYLOR f Optometrists of Ontario

26 which is the Mr. HARRY SIMON pline and qualifying body operatin

27 under The Op Mr. J.L. WHITNEY ich statutes and regulations

28 we go to the Mr. L.E. TURNER ith when am-- Secretary necessary

29 It is in the spirit of co-operation with other professions

30 that these briefs have been----- ed for your consideration.







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SUBMISSION OF

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APPEARANCES:

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Mr. I. Baker

Mr. E. F. Attridge

Mr. J. Duffy

Mr. R. J. Broad

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this is the delegation of the Optometrical Association.

Have you read the instructions on the table

before you? said in the briefs, the most important point that

we seek to make Who is the spokesman who wishes to introduce the

your delegation? considering the Bill from the point of view

of the people MR. LAMONT: Mr. Chairman and ladies and gentle-

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desire of our There are, as you know, two briefs filed. One

from the Ontario Optometrical Association which is the voluntary

body from Ontario and the practising optometrists, and the

other brief is from the College of Optometrists of Ontario,

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Mr. I. Baker  
Mr. E. F. Attridge  
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2 two briefs are pretty similar and for that reason to assist  
3 this Committee in saving time the two groups are sitting at  
4 the table as one delegation to answer such questions as may  
5 be put to the groups if desired.

6 THE CHAIRMAN: I understand these will cover  
7 both briefs? Mr. James Duffy who is Managing Director of the

8 Optometrical Association. MR. LAMONT: One group representing the two  
9 briefs.

10 I think that no matter what is said this morning  
11 or what is said in the briefs, the most important point that  
12 we seek to make to the Committee is that we wish to assist the  
13 Committee in your considering the Bill from the point of view  
14 of the people of this province who may wish vision care as  
15 provided under the Bill and the best way of making that pro-  
16 vision available no matter what is said. That is the main  
17 desire of our group, to assist your Committee in seeing what  
18 is the best way of providing care under the Bill, the services  
19 that are in the Bill.

20 The delegation is comprised of E. F. Attridge,  
21 in the center, who is the President of the College of  
22 Optometrists; and training of health care professions whose

23 members are 11 Mr. R. J. Broad, sitting at the end of the table,  
24 who is the President of the Ontario Optometrical Association;

25 while including Mr. Marvin Langer, to my immediate left, who is



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The delegation is comprised of E. R. Attridge, in the center, who is the President of the College of Optometrists; Mr. R. J. Broad, sitting at the end of the table who is the President of the Ontario Optometrical Association; Mr. Marvin Langer, to my immediate left, who is





1 a practising optometrist in this city and is a member of the  
2 Social and Health Trends Committee of the Optometrical Associa-  
3 tion;

4 Mr. I. Baker, a member of the Board of the  
5 College of Optometrists;

6 And like myself a layman -- I am the lawyer of  
7 the Board -- Mr. James Duffy who is Managing Director of the  
8 Optometrical Association.

9 I think, if we may proceed with Mr. Attridge  
10 who has some preliminary remarks to make to your Committee.

11 MR. ATTRIDGE: Dr. Hagey, ladies and gentlemen  
12 of the Medical Services Insurance Enquiry, Ontario Optometrists  
13 believe the government is to be commended on Bill 163, insofar  
14 as its purpose is concerned.

15 However, as you will have gathered from our  
16 briefs, we have grave misgivings over certain aspects of this  
17 legislation.

18 Optometry's views concerning prepaid health  
19 programs, already stated publicly, are that today's needs can  
20 best be met by voluntary prepaid health programs available to  
21 all; comprehensive in coverage and utilizing the special  
22 talents, skill and training of health care professions whose  
23 members are licensed to practise. Our objections to Bill 163  
24 lie its failure to utilize the various health care professions  
25 while including many of the services which they provide.



23 While including many of the services which they provide.  
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45 a practising optometrist in this city and is a member of the





1 In our view no government legislation, nor indeed  
2 any private development in health insurance programs, should be such  
3 that it can impede the orderly and necessary development of  
4 professions in the health care field. As such programs fall  
5 and mature they will themselves require increased numbers of  
6 all health care personnel to provide the benefits to an ever  
7 increasing population in this province. Yet one effect of  
8 Bill 163 is certainly to so impede the development of optometry  
9 to the detriment of the public.

10 To date only the medical profession and insurance  
11 carriers seem to have been directly involved in the proposed  
12 government legislation. Mr. Chairman, it would appear that  
13 Bill 163 is just what the doctor ordered. This has resulted,  
14 we believe, in an unduly restricted point of view which, in the  
15 long term, is likely to prove harmful both to the plan and the  
16 public which it is designed to serve.

17 Present insurance plans, and the proposed legis-  
18 lation, are generally referred to as providing "medical"  
19 services when, in fact, they include "health" services.  
20 Certainly, they include "optometric" or "vision care" services  
21 while excluding optometrists, who are by far the numerically  
22 larger group in this field and who provide the far greater  
23 proportion of vision care services, that is excluding the  
24 medical and surgical aspects of eye care. Curiously Bill 163  
25 excludes optometrists thus aggravating a situation which is

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1 discriminatory in effect and completely impractical insofar as  
2 providing the services to a large percentage of the public is  
3 concerned.

4 Optometry is not advocating an extension of  
5 benefits under the Bill. Our point is that when optometric  
6 services are provided, then optometric practitioners must  
7 participate. We would be averse also to reducing any benefits  
8 and particularly those which help to improve the well-being  
9 of the people of this province.

10 Mr. Chairman, I would like to emphasize that it  
11 is not possible to disassociate vision care services from  
12 medical care or health care services, and if any of the members  
13 of the Enquiry would care to ask questions concerning this  
14 during the question period we would be pleased to discuss it.

15 Certainly it is not necessary to emphasize to  
16 the members of this Committee the important part which clear  
17 comfortable efficient vision plays in the lives of all age  
18 groups.

19 We speak of "vision care" benefits in Bill 163.  
20 By this we mean those procedures not excluded in Schedule A  
21 which optometrists are duly qualified to perform and which are  
22 also to be found in the Schedule of Fees of the Ontario Medical  
23 Association. Broadly speaking, this would include all optome-  
24 trical diagnostic techniques and a number of treatment  
25 procedures.

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We speak of "vision care" benefits in Bill 103  
by this we mean those procedures not excluded in Schedule A  
which optometrists are duly qualified to perform and which are  
also to be found in the Schedule of Fees of the Ontario Medical  
Association. Broadly speaking, this would include all optometric  
diagnostic techniques and a number of treatment





1 Refraction, perimetry and campimetry, tonometry  
2 and orthoptics are specified items in the Ontario Medical  
3 Association tariff which optometry by legal right and training  
4 provide their patients.

5 The majority of people requiring these services  
6 do obtain them from optometrists and if Bill 163 should go into  
7 effect in its present form these services would be unavailable  
8 to a large majority of those insured. And more particularly  
9 Bill 163 as it stands make provision for vision care of some  
10 600,000 indigents who have no organized vision care program  
11 available to them today. Also there are another 600,000 who  
12 may be classed as semi-indigent who would benefit from these  
13 provisions. Optometry congratulates those who in, drafting  
14 this Bill, foresaw this unmet need in the field of vision care  
15 and provided for it. This is a very important aspect of Bill  
16 163 but these citizens will not be able to receive this benefit  
17 unless the profession of optometry is included.

18 In the last few years we have heard a great deal  
19 about freedom of choice. Bill 163 would be a negation of the  
20 spirit and intent of this legislation if it could not provide  
21 complete freedom of choice of the legally and academically  
22 qualified professions. I noticed, Mr. Chairman, in the recent  
23 bulletin, that the Board of Trade of Metropolitan Toronto  
24 emphasized this point in their submission to this Enquiry.

25 We did not elaborate on the matter of cost in



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1 either brief because, if the benefit is included, the cost  
2 ought not to be affected by the inclusion or exclusion of  
3 optometrists.

4 Actually, ladies and gentlemen, we think that  
5 the most serious defect from your consideration is that although  
6 it will appear to the public that vision care is provided for  
7 in the Bill the simple fact is that it will not be available  
8 though they will have paid for it. It is not my intention to  
9 use strong words but I feel I am forced to say that this would  
10 be deceiving the public. We do not believe that the government  
11 would have any part of such dealings.

12 The short-term and long-term effects upon the  
13 patient-optometrist relationship, the recruitment of future  
14 optometry students, the profession itself and the public  
15 welfare have been dealt with fully in our submissions to this  
16 Committee. We mention these only to remind the Committee of  
17 the far-reaching effects of Bill 163, or similar legislation.

18 We have made no attempt to discuss any details  
19 of Bill 163 other than its failure to recognize in principle  
20 and in fact, the need for optometric inclusion if the public  
21 is to be given the vision care which is required and provided  
22 by the Bill.

23 We believe that in the light of what has been  
24 said it is the responsibility of this Committee to deal with  
25 this matter. This is not a matter of administrative detail; it



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12 The short-term and long-term effects upon the  
13 patient-optometrist relationship, the recruitment of future  
14 optometrists, the relationship between the optometrist and the public  
15 and the relationship between the optometrist and the Government  
16 are all affected. The Bill is a very serious one and it is  
17 very important that we should have a full and frank discussion  
18 of it. It is not my intention to use strong words but I feel  
19 I am forced to say that this would be deceiving the public.  
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1 is one of principle, of equity and of the utmost importance  
2 to the public welfare.

3 If the broad general principles governing Bill  
4 163 as enunciated by Premier Robarts and reported in the  
5 Toronto Daily Star on April 24th, 1963 are to be met and the  
6 purpose of Bill 163 is to be fulfilled then three things are  
7 required.

8 (1) Optometry, being the largest group in the  
9 vision care field and providing most of the services, which  
10 are provided for by the Bill, should be part of any group or  
11 groups studying this problem and future legislation that follows  
12 as a result of these hearings.

13 (2) That Bill 163 or its successor provide for  
14 the participation of optometrists in rendering all services  
15 included in such legislation, which they are duly qualified to  
16 perform.

17 (3) That, following the inception of such  
18 legislation, optometry be represented on its policy and adminis-  
19 trative organization.

20 The College of Optometrists of Ontario and the  
21 Optometrical Association of Ontario believe most strongly that  
22 these are necessary and basic actions not only to fulfil the  
23 purpose of Bill 163 but also to assure that the people of this  
24 province receive now and will be assured in the future of the  
25 availability of vision care services of the highest order. It



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1 is to this end that we are here today and that our submissions  
2 have been made.

3 Mr. Chairman, we will be pleased to answer your  
4 questions. May I have your permission to direct these questions  
5 to the various members of our delegation in order that you may  
6 have the benefit of their accumulated experience.

7 THE CHAIRMAN: Thank you.

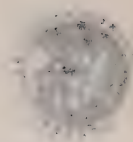
2 8 Miss McArthur?

9 MISS McARTHUR: I have a couple of questions.

10 The delegation, by your submissions, has  
11 recognized that there are other groups in the health profession  
12 that would be involved on the principles as enunciated in this  
13 brief of the Optometrical Association of Ontario and which you  
14 say it could not -- the total service could not be provided.

15 These other groups, such as being a nurse,  
16 particularly in a community where there is no medical profession  
17 available to the community, I am wondering if you thought  
18 through the question if it has to be this Bill, or this service  
19 has to be implemented in steps if priorities have to be  
20 established in relation to the kinds of services we require  
21 for a comprehensive service where you see eye care fitting into  
22 the total picture.

23 MR. BAKER: This, Miss McArthur, is an interesting  
24 question, and I don't know whether I can answer it specifically.  
25 The thing that concerns us is that in fact Bill 163 exists and



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MR. BAKER: This, Miss McArthur, is an interesting

question, and I don't know whether I can answer it specifically

The thing that concerns us is that in fact Bill 103 exists and





1 in fact vision care services are included in it. My under-  
2 standing is that the reason that we are here is to discuss Bill  
3 163.

4 Now, if in the government's wisdom they want to  
5 stagger the inclusion of various types of health care in some  
6 type of sequence, I think our profession would be very pleased  
7 to participate in such discussions. So, this type of staging,  
8 if proved to be useful and necessary and desirable, I think  
9 our profession would be prepared to discuss this and make its  
10 contribution.

11 However, I think the point here, and this is  
12 the point that concerns us, that in fact there is no provision  
13 of staging in this present Act. Optometric services are in-  
14 cluded in this Act. If this Act goes into effect as it now  
15 stands, that optometrists would be excluded from participating  
16 in it. We have maintained a position and I think we have made  
17 a fairly good argument, that this benefit cannot be given to  
18 the public generally under the present situation.

19 I think, in answer to your question, I would  
20 say this, that if there was an attempt at staging the develop-  
21 ment of health care services being made available to the public,  
22 I think yes our profession would be prepared to participate in  
23 such discussion and we have to stage it properly. I do not  
24 think this is the case in point at the moment.

25 One of the problems here, and I think it will

in fact vision care services are included in it. My understanding is that the reason that we are here is to discuss Bill

163.

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One of the problems here, and I think it will





1 constantly recur, is that it is very difficult to disassociate  
2 in any kind of staging, as I see it, diagnostic techniques.  
3 This, in effect is what this Bill offers to a very large  
4 extent -- is a series of tests of techniques by many practi-  
5 tioners in order to determine what the problem of that  
6 particular patient is. I am not too sure how simple it is.  
7 I have an idea it is complex to try to take out diagnostic  
8 technique 1, 2, 3, 4 and stage them in this way. I do not  
9 think it is that easy to isolate diagnostic techniques.

10 MISS McARTHUR: I have one other question.

11 I was wondering in those communities, and I  
12 notice in the brief there is a list of communities where there  
13 are optometrists and ophthalmologists.

constantly recur, is that it is very difficult to dissociate  
in any kind of staging, as I see it, diagnostic techniques.  
This, in effect is what this Bill offers to a very large  
extent -- is a series of tests of techniques by many practi-  
tioners in order to determine what the problem of these  
particular patient is. I am not too sure how simple it is.  
I have an idea it is complex to try to take out diagnostic  
technique 1, 2, 3, 4 and stage them in this way. I do not  
think it is that easy to isolate diagnostic techniques.  
MISS MORTIMER: I have one other question.

I was wondering in those communities, and I  
notice in the by-laws as a list of communities where there



1 MISS McARTHUR: I have one other question.  
2 I was wondering in those communities, and I  
3 notice in the brief there is a list of communities where there  
4 are optometrists and ophthalmologists. In those communities  
5 where there are both professions available to the community  
6 is there in any way, any joint planning in the eye care or  
7 occasions where the two groups work together as a team in  
8 giving services to the community?

9 MR. ATTRIDGE: I would say in many areas there  
10 is the finest co-operation. Just how close this co-operation  
11 is throughout the whole province, I can't say. I know there  
12 are many areas where the two groups practise that there is  
13 definite co-operation. I would say there is no special agree-  
14 ments. It is just co-operation.

15 MR. BROAD: There are other occasions, Miss  
16 McArthur. One instance is in the City of Hamilton where, I  
17 believe, the optometrists and ophthalmologists work together on  
18 the school vision program. They work together.

19 MR. ATTRIDGE: They have for several years.

20 MISS McARTHUR: Is there any such thing as  
21 actual clinics, for instance, where the two work together?

22 MR. ATTRIDGE: Not to my knowledge.

23 MISS McARTHUR: I think those, at the moment are  
24 all the questions I have. I may have something later, sir.

25 THE CHAIRMAN: Thank you. Mr. Coulter.





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are optometrists and ophthalmologists. In these communities

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THE CHAIRMAN: Thank you. Mr. Coulter.



1 MR. COULTER: Mr. Chairman, and gentlemen I  
2 think firstly you should be complimented on both of your  
3 briefs. They are, I am sure, quite explanatory to people who  
4 understand medical terminology, but me being a layman, I would  
5 like you to explain it to me the terminplogy of refractions,  
6 the term "refraction", what does this really mean in layman's  
7 language? I hate to appear so dumb, but I would like it  
8 explained to me.

9 MR. ATTRIDGE: I think, perhaps, the simplest  
10 way of explaining it is to say that a person comes to the  
11 conclusion that certain symptoms, signs or obvious poor vision  
12 directed his attention to his eyes and he decides he has to  
13 go somewhere and find out whether or not, in fact, he has a  
14 problem. I think that one of the confusing things from our  
15 point of view is the word "refraction", as well. I think to  
16 try and explain it in the terms that I think you wish it to be  
17 explained, I think you would just go somewhere, to someone  
18 that you knew was qualified to do this and say I have this  
19 sequence of events occurring to me and what I want to know is  
20 do I have a problem, can I be helped, is this a medical problem  
21 or isn't it a medical problem and if so where should I go.  
22 All the procedures that a practitioner would carry out during  
23 this visit in order to determine whether or not the sequence  
24 of events which caused me to come to him, if the eyes were  
25 responsible for it and all the procedures, and there is a



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this visit in order to determine whether or not the sequence

of events which would be so much to him, is the first

responsibility for it and all the procedures, and then it is





1 multiplicity of them, all of the procedures that would be  
2 carried out is generally referred to as a refraction.

3 MR. COULTER: Further to Miss McArthur's question  
4 in regards to medical people practising vision care or eye  
5 care in the Province there are few, really. With the number of  
6 people that have to have eye care or refractions, and if the  
7 Bill were left as it is where optometrists would be excluded,  
8 on referral how long would I have to wait, in your opinion,  
9 before I could get in to see a medical man to have my eye care?

10 MR. BROAD: Well, I believe at the present time  
11 this waiting period is anywhere from two to three months, and  
12 I think if you increase this work load by doing as you suggest,  
13 leaving the Bill as it is and sending all the refractions to  
14 the medical practitioner the waiting time would likely be  
15 increased greatly.

16 MR. BAKER: There would be one other side point  
17 I would like to add to that. There is a relatively long delay.  
18 The thing that one perhaps isn't aware of is that many, many  
19 people, and we as practising optometrists are very aware of  
20 this, many, many people do have these programs that exist now  
21 in this form, actually will not put up with this and will  
22 go outside of the plans at their own expense in order to get  
23 services that they feel they require now, so that the only  
24 reason -- though it is a relatively long period of time now it  
25 is not as long as it would be if everybody insisted on rates

multiplicity of them, all of the procedures that would be carried out is generally referred to as a refraction.

MR. COUNNER: Further to Miss McArthur's question

in regards to medical people practicing vision care or eye care in the Province there are few, really. With the number of people that have to have eye care or refractions, and if the Bill were left as it is where optometrists would be excluded on referral how long would I have to wait, in your opinion, before I could get in to see a medical man to have my eye care?

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reason -- though it is a relatively long period of time now



1 within the present plans that are in effect, because each one  
2 of us in his practice every day have a number of people from  
3 prepaid insurance plans which are in effect now, but they just  
4 disregard the benefit for which they paid in order to obtain  
5 services.

6 MR. COULTER: Are you saying there are some  
7 plans in effect today that people purchase either through group  
8 or else by purchasing it themselves on their own personal  
9 basis, they have refractions covered in their plan and when it  
10 comes down to the optometrist he doesn't have?

11 MR. LANGER: That is correct.

12 MR. ATTRIDGE: That is correct.

13 MR. COULTER: That is what happens today. In  
14 this case, if this happens I think you said that people then  
15 say well, I thought I had it covered, so do they then buy the  
16 glasses or have the refractions or do they go on out of your  
17 office and go on to somebody else that covers it?

18 MR. BAKER: No, they stay, most of them. As a  
19 matter of fact I shouldn't say they stay. They come in knowing  
20 they are not covered under the plans they purchased.

21 MR. LANGER: I would like to modify that a bit  
22 if I may. My own experience would be certainly not everybody  
23 is aware when they come into my office that they are not covered  
24 under the provisions of the plan. In fact, my impression would  
25 be quite the reverse, that the majority are not aware that the





1 certain the Government is not going to pay for the  
2 of the Government's property and a number of people who  
3 property of the Government is not going to pay for the  
4 disregard the benefit for which they paid in order to obtain  
5 property.

6 MR. COUNTER: Are you saying there are some  
7 plans in effect today that people purchase either through Gro  
8 or else by purchasing it themselves on their own personal  
9 basis, they are not going to pay for it?  
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11 MR. LANGER: That is correct.  
12 MR. ATTRIDGE: That is correct.

13 MR. COUNTER: That is what happens today. In  
14 this case, if this happens I think you said that people then  
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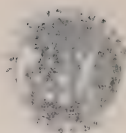
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21 MR. LANGER: I would like to modify that a bit  
22 if I may. My own experience would be certainly not everybody  
23 is aware when they come into my office that they are not covered  
24 under the provisions of the plan. In fact, my impression would  
25 be that the majority of the people who come in and say they are



1 benefit is not available to them since they feel they have  
2 paid for the benefit and in many plans it is stated in terms  
3 something of this order: A refraction that is an examination  
4 for eye glasses is provided for as a benefit under this plan  
5 after a waiting period of one year. I find that many people  
6 do when they are informed that they are not covered, many people  
7 do feel since I have paid for this benefit I should get it and  
8 it would be foolish for me to pay a second time to you. Moreover  
9 as these plans have been in existence for many years we find  
10 that a number of our patients who may have perhaps decided on  
11 the first occasion that they would pay outside the plan sub-  
12 sequently feel, well, I have paid for this benefit and I should  
13 receive it and therefore choose another practitioner where the  
14 service is available. My feeling is the existing plans most  
15 seriously interfere with the choice of the practitioner on the  
16 part of the subscriber.

17 MR. ATTRIDGE: May I add to that as well, Mr.  
18 Chairman. We know that in 1961 there were 600,000 -- is that  
19 the correct figure -- examinations performed by optometrists in  
20 Ontario. We don't know the figure for 1962 at the moment, but  
21 1961 would be a good example. Now, if you were going to add  
22 600,000 more examinations to the medical refractionists who  
23 number less than one-third the number of optometrists in the  
24 province how can they cope with the situation in the first place.  
25 In the second place that would interfere, I feel, with their



1 benefit is not available to them since they feel they have  
2 said for the benefit and in fact when it is stated in the  
3 something of a nature, a provision that in the meantime  
4 for the benefit is provided for as a benefit under this plan  
5 about a waiting period of one year. I think that many people  
6 do not feel any interest that they are not interested in any  
7 do feel since I have said the rule because I know that it is  
8 it would be better for me to pay a certain time in the  
9 as these plans have been in existence for many years as I  
10 that a number of the people who have been working under the  
11 the first condition that they would pay for the plan and  
12 regularly feel well, I have said for this benefit and I think  
13 because it is a condition that they would pay for the plan and  
14 service is available, as stated in the plan and I think  
15 seriously interested with the value of the plan and I think  
16 part of the subscriber.

17 MR. ATTORNEY: May I add to that as well, Mr.  
18 Chairman. We know that in 1961 there were 600,000 -- as that  
19 the present figure -- and we know that in 1962 at the moment, but  
20 Ontario. We don't know the figure for 1962 at the moment, but  
21 1961 would be a good figure, and I think that is all  
22 600,000 were estimated as the number of subscribers in the  
23 number less than one-third the number of subscribers in the  
24 province now and that was with the situation in the first five  
25 in the second place was well known, I think with regard





1 medical and surgical work which is vitally important and they  
2 are not the only people capable of taking care of eye glasses.  
3 There is no confusion there.

4 MR. COULTER: Just one more questions, Mr.  
5 Chairman. It may be a little bit below the belt, and if you  
6 don't wish to answer you don't have to. Due to the area of  
7 conflict, and I am not sure what is the reason for it within  
8 my own frame of mind here, what would be your opinion if vision  
9 care was deleted entirely from Bill 163?

10 MR. ATTRIDGE: Would you like to answer that,  
11 Mr. Langer?

12 MR. LANGER: You must consider one of the prime  
13 purposes of Bill 163 was to ensure that all people would be  
14 able to purchase comprehensive medical care plans, and to make  
15 provision for the indigent low income population receiving  
16 such coverage. Dr. Dymond has suggested some 1,200,000 people  
17 would require full or partial assistance in purchasing such a  
18 program, and if you look at Schedule C under the Act the pro-  
19 portion of older people in these groups of low income people  
20 is quite high, the very groups where requirements for vision  
21 care is the greatest. The present provisions in this province  
22 for providing vision care to this group is very minimal, while  
23 the Ontario Medical Welfare Plan makes, at least, some minimal  
24 provision for medical care for about 225,000 people, in contrast  
25 to this there has been direct provincial assistance to only an



1 ...  
2 ...  
3 There is no confusion there.  
4 MR. COURTNEY: Just one more question, Mr.  
5 Chairman ...  
6 don't wish to answer you don't have to. Due to the area of  
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8 ...  
9 care was deleted entirely from Bill 163?  
10 MR. ATTRIDGE: Would you like to answer that?  
11 Mr. Langer?  
12 MR. LANGER: You must consider one of the prime  
13 ...  
14 able to purchase comprehensive medical care plans, and to make  
15 ...  
16 such coverage. Dr. Dymond has suggested some 1,200,000 people  
17 would require financial assistance in purchasing such a  
18 program, and if you look at Schedule C under the Act the pro-  
19 portion of older people in these groups of low income people  
20 is quite high, the very groups where requirements for vision  
21 care is the greatest. The present provisions in this province  
22 for providing vision care to this group is very minimal, while  
23 the Ontario Medical Welfare Plan makes, at least, some minimal  
24 provision for medical care ...  
25 in this case has provided financial assistance to ...



1 estimated 2,600 people of the Province of Ontario each year  
2 for vision care. Obviously there is an urgent need for  
3 assistance to this category of people, and I would think that  
4 it would be a complete negation of the spirit and intent of  
5 the legislation to remove a benefit which has such wide  
6 application and for which there is such an urgent need, and  
7 furthermore I have grave doubts as to whether it is possible  
8 to exclude this profession. As has been mentioned ordinarily  
9 the average person that doesn't do what the definition of  
10 prepaid plans suggest, the average patient doesn't come to us  
11 to have his eyes examined to get glasses. They prefer we tell  
12 them it isn't necessary. They come with problems, with  
13 symptoms and they are interested in determining if these  
14 symptoms are ocular in nature and what needs to be done about  
15 them. If this Bill 163 makes provision for general medical  
16 services then it seems to me that these people would be  
17 qualified to visit a physician on that basis. I think Mr.  
18 Walpole of Windsor Medical has brought this to the attention  
19 of the Commission in an earlier submission when he pointed out  
20 that excluding the annual medical check-up it is very difficult  
21 in that people obtain it under another guise. I think exactly  
22 the same situation obtains here. The exclusion would have only  
23 one effect, it would exclude optometrists. It wouldn't exclude  
24 the patient, the subscribers obtaining the benefit. I believe  
25 there is some experience in this respect with present plans





1 estimated 2,500 people of the Province of Ontario each year  
 2 for vision care. Obviously there is an urgent need for  
 3 assistance in this respect. It is not clear that  
 4 it would be a simple matter to set up such a service.  
 5 the legislation to remove a benefit which has such wide  
 6 application and which has been in force for many years,  
 7 I am sure I say, is a matter of great importance.  
 8 to exclude this profession. As has been mentioned ordinarily  
 9 the average person that doesn't do what the definition of  
 10 prepaid plans suggest, the average patient doesn't come to us  
 11 to have his eyes examined to get glasses. They prefer we tell  
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 22 the same situation obtains here. The exclusion would have only  
 23 one effect, it would exclude optometrists. It wouldn't exclude  
 24 the patient, the subscribers obtaining the benefit. I believe



1 which exclude refraction for safety glasses. This is a very  
2 difficult if not impossible exclusion to make because if the  
3 patients present themselves for attention they are eligible  
4 for such attention under the plan. With all these considera-  
5 tions in mind I think the fact that the need is not met in  
6 present plans for the indigent and low income population, the  
7 fact that in fact to exclude the so-called refraction benefit  
8 is most difficult to do. I am not suggesting that the  
9 practitioner would practise fraud on the plan. I am just  
10 saying if the patient has a diagnostic service available from  
11 a physician he would then be eligible to receive these services  
12 if he presented his problem to the practitioner in the proper  
13 way. Therefore we would be most adverse from the standpoint  
14 of the welfare of the public to see such an exclusion take  
15 place. I think in the most recent review of ophthalmic services  
16 in England and Wales by Professor Almont Lindsay, who is a  
17 professor of history, he said that the overall figures with  
18 respect to the national health service left little doubt that  
19 despite the charges that were made for this service no branch  
20 of the Health Service was more widely and deeply appreciated  
21 than the ophthalmic service. I think it would be impossible to  
22 make such an exclusion.

23 MR. COULTER: Thank you. That is all I have  
24 at the present time.

25 THE CHAIRMAN: Dr. Galloway.

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at the present time.

MR. GOWEN: Thank you. That is all I have





1 DR. GALLOWAY: I have a few questions. I would  
2 like to explain to most of you although I hold a medical degree  
3 my knowledge of ophthalmology is such I am sure you should con-  
4 sider me as a lay person. Any questions I ask will be taken  
5 on the basis I know very little about this subject. To clarify  
6 one thing for me, I understand the oculist is the medical  
7 man specializing in the practice of the eye. Optometrists you  
8 have well explained in your brief. What is the difference  
9 between an optometrist and an optician?

10 MR. ATTRIDGE: The optician doesn't examine the  
11 patient. He is the distributor. He fills the prescription  
12 that is written by the optometrist or ophthalmologist.

13 DR. GALLOWAY: Do you as an optometrist refer  
14 patients to opticians or do you supply your own glasses?

15 MR. ATTRIDGE: We do both.

16 DR. GALLOWAY: What is the general practice?

17 MR. ATTRIDGE: Many patients prefer that we  
18 follow the case through and we engage laboratories to fill  
19 prescriptions and then we see the prescription is correctly  
20 filled and properly fitted to the patient. I must say that  
21 there is advantage in that procedure because when I examine a  
22 patient and write the prescription I see that prescription is  
23 correctly filled and correctly fitted to the patient. It gives  
24 me the opportunity to see the results of my work.

25 DR. GALLOWAY: In those cases in which you

DR. GALLOWAY: I have a few questions. I would like to explain to most of you although I hold a medical degree my knowledge of ophthalmology is such I am sure you should consider me as a lay person. Any questions I ask will be taken on the basis I know very little about this subject. To clarify one thing for me, I understand the oculist is the medical person who is responsible for the health of the eye. I have well explained in your brief. What is the difference between an optometrist and an oculist?

MR. ATHERIDGE: The oculist doesn't examine the patient. He is the distributor. He fills the prescription that is written by the optometrist or ophthalmologist.

DR. GALLOWAY: Do you as an optometrist refer patients to opticians or do you supply your own glasses?

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DR. GALLOWAY: In those cases in which you



1 yourself make the diagnosis for the need for glasses and you  
2 make the prescription and have it subsequently filled either  
3 by yourself or by an optician how do you regulate your charges?

4 MR. ATTRIDGE: All my charges are made on a  
5 fee for service, and when I use materials the materials are  
6 passed on to the patient at laboratory costs.

7 DR. GALLOWAY: Let me put this question in  
8 another way: Do you have two charges or one charge, one for  
9 the refraction and one for the buying of the glasses and  
10 fitting of them?

11 MR. ATTRIDGE: I have several charges. I have  
12 a fee for the examination and I have a fee for the work that  
13 has to be done in dispensing them. As far as the materials  
14 themselves are concerned the patient pays what I have paid the  
15 laboratory.

16 DR. GALLOWAY: What fees would the Medical  
17 Health Insurance Plan anticipate getting from the optometrists?

18 MR. ATTRIDGE: You mean....

19 DR. GALLOWAY: Of these three fees you have,  
20 that you charge to the patient, which of them would be held  
21 responsible?

22 MR. ATTRIDGE: The diagnostic fee.

23 DR. GALLOWAY: How much is that on an average?

24 MR. ATTRIDGE: \$10.00.

25 DR. GALLOWAY: Is that a standard fee throughout





1 I have been asked to examine the materials and to report on the results of the examination.  
2 I have examined the materials and have found them to be of a high quality.  
3 The materials are of a high quality and are well preserved.

4 MR. ATTORNEY: All my charges are made on a  
5 fee for service, and when I use materials the materials are  
6 passed on to the patient at laboratory costs.

7 DR. GALLOWAY: Let me put this question in  
8 another way. Do you have any charges for the materials and for  
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19 responsible?

20 MR. ATTORNEY: The diagnostic fee.

21 DR. GALLOWAY: How much is that on an average?

22 DR. GALLOWAY: Is that a standard fee throughout



1 the province or is that your individual fee?

2 MR. ATTRIDGE: No, it is the Association  
3 Schedule of Fees.

4 DR. GALLOWAY: One sees as you are driving  
5 around, particularly in Toronto and listening to the radio a  
6 great number of advertisements, "Come in for free examinations,  
7 if you don't need glasses you will be told so and if you do  
8 then you will have them supplied to you". Are these services  
9 being carried on by optometrists or opticians and is it really  
10 a free service?

11 MR. ATTRIDGE: Well, I don't know where this  
12 line of questioning is leading.

13 DR. GALLOWAY: If you would like me to explain,  
14 I am trying to eventually determine how much money the basic  
15 plan in which we are interested in establishing is going to  
16 eventually have to pay.

17 MR. BAKER: Now, on that basis I would be very  
18 glad, Dr. Galloway, to answer specific questions. On this basis  
19 I think we could make this statement and I think we have  
20 indicated it in our submission, the College of Optometrists'  
21 submission, that in fact there are vision care benefits in the  
22 Bill. I think we would all agree about this. If they were  
23 academically based on the incidence of the anomalies of the  
24 population and the utilization rate of the population for that  
25 particular service then it really doesn't really matter who



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around, particularly in Toronto and listening to the radio a great number of advertisements, "Come in for free examinations if you don't need glasses you will be told so and if you do then you will have them supplied to you". Are these services being carried on by optometrists or opticians and is it really a free service?

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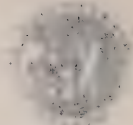




1 provides the service because it doesn't cost any more or any  
2 less to have one kind of practitioner to supply it or another  
3 kind of practitioner supply it. So in terms of the question as  
4 you put it to me now it really doesn't make any difference to  
5 the cost of the plan whether optometrists are included or  
6 excluded from it. The only variation could be that it would  
7 cost less if optometrists were excluded from the program  
8 simply because most people could not use it but if they could  
9 use it, as they could if the optometrists were included in the  
10 Bill, then the cost remains a static amount so that it does  
11 not influence the total cost of the service to the Bill if it  
12 has been provided for properly, actuarially.

13 To answer your other question, our profession is  
14 organized, like the dental and medical professions, and I  
15 presume the legal profession in a way in which there is a  
16 tariff or schedule of suggested fees to the practitioners.  
17 There are a multiplicity of services. Each one has had a  
18 dollar sign placed beside it. The Bill, as it stands now is  
19 primarily, not completely but primarily for diagnostic services,  
20 and there is no difficulty in establishing charges for them  
21 in this schedule because our fee schedule has been oriented in  
22 this direction for many many years. This is so.

23 The other aspect which you have brought up is  
24 certainly we have problems within our own profession. We have  
25 people who do not play the game the way we would like them to.



1 provided the service is provided in a way that is not  
2 in the case of a service which is provided in a way that is not  
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4 in the case of a service which is provided in a way that is not  
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7 be that if optometrists were included then the cost would  
8 be that if optometrists were included then the cost would  
9 and it, as they could if the optometrists were included in the  
10 Bill, then the cost remains a static amount so that it does  
11 not influence the total cost of the service to the Bill. It is  
12 has been provided for properly, accordingly.

13 To answer your other question our profession is  
14 organized, like the dental and medical professions, and I  
15 presume the legal profession in a way in which there is a  
16 tariff or schedule of suggested fees for the practitioners.  
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19 primarily, not completely but primarily for diagnostic services  
20 and there is no difficulty in establishing charges for them  
21 in this schedule because our fee schedule has been oriented in  
22 this direction for many years. This is so.

23 The other aspect which you have brought up is  
24 certainly as much a problem as the other professions. We have  
25 people who do not play the game the way we would like them to.



1 I suspect that most groups have this problem. Ours may be a  
2 little bit more overt than other groups. Maybe that is a good  
3 thing because they can be easily identified but it is not a  
4 wrong conclusion to draw, or attempt to draw that the vast  
5 majority, 90% or even higher of the men in this field practise  
6 in a way which is in keeping with the objects and goals of our  
7 profession, and there is no problem.

8 On the other hand, just to make this clear, and  
9 this may be very useful in this regard, if a person knows that  
10 these services are paid for, I suspect that they will tend to  
11 choose their practitioner on the basis of his reputation and of  
12 his ability rather than on the fact that perhaps one place is  
13 somewhat less expensive than another so there may be, in fact,  
14 a very worthwhile side effect of this type of legislation and  
15 I think that everyone would agree that if services are paid for  
16 within a profession which still is highly competitive, as it  
17 has always been and this is a good thing, not a bad thing,  
18 people will tend to gravitate towards the better practitioner.  
19 From the public point of view this is a good thing. I have  
20 tried to answer your question Dr. Galloway.

21 DR. GALLOWAY: If I have by any chance given you  
22 the impression I have any disrespect for your profession, I  
23 certainly wish to correct that. There is no thought in my mind  
24 in that regard at all.

25 In the type of examination that you carry out,





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12 somewhat less desirable than the one that we have now, in that  
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14 choose their practitioner on the basis of his reputation and  
15 that might be the case. I would think that they will tend to  
16 that may be very useful as this remedy is a valuable thing that  
17 On the other hand, just to make this clear, and  
18 profession, and there is no problem.



1 what would be the major difference between what you do and what  
2 the ophthalmologist does? Is there any major difference? In  
3 regard to fees I mean.

4 MR. BAKER: In regard to fees?

5 DR. GALLOWAY: What I am thinking about is fees  
6 and why is there a difference in fees if you are both accom-  
7 plishing the same thing.

8 MR. BAKER: I don't know whether there is in  
9 fact a difference in fees sir. I am not aware that there is  
10 a marked or any discrepancy in fees.

11 DR. GALLOWAY: Would the two examinations then  
12 be comparable, one to the other?

13 MR. BAKER: In terms of fees?

14 DR. GALLOWAY: No, in terms of examination.

15 MR. BAKER: I think that in usefulness to a  
16 patient it would be my personal opinion, because you have to  
17 ask the ophthalmologist his sir, but it would be my personal  
18 opinion that the public gets good and equal services.

19 DR. GALLOWAY: My final question: How much  
20 reference is there between the two professions? In your own  
21 practice, for example, would you refer ten, twenty, thirty,  
22 forty per cent?

23 MR. BAKER: I can answer that, if I may, Mr.  
24 Chairman as I was responsible for doing a study of our group  
25 over a period of years and that study was presented initially in

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2 the optometrist does? Is there any major difference? In  
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20 practice, for example, would you refer ten, twenty, thirty,  
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23 Chairman as I was responsible for doing a study of our group  
24 over a period of years and that study was conducted initially





1 Canadian Journal of Optometry and more latterly at the Royal  
2 Commission hearings. We found that in our survey between four  
3 and six per cent of the patients who presented themselves to  
4 optometrists were referred for medical consultation and that  
5 according to our studies, and the literature, both medical and  
6 optometrical, is about the incidence of ocular pathology in  
7 the general population.

8 DR. GALLOWAY: If the patient is referred by  
9 the ophthalmologist to the optometrist for glasses, would the  
10 plan anticipate receiving an account from the optometrist?

11 MR. BAKER: No, I don't think the plan would  
12 anticipate because in fact those services which the optometrist  
13 would render, under those conditions, would not fall within the  
14 benefits being offered by the present Bill.

15 DR. GALLOWAY: Thank you very much.

16 THE CHAIRMAN: Mr. Whitney?

17 MR. WHITNEY: Mr. Chairman, this person called  
18 an optician, would you tell me more about an optician, giving  
19 me the distinction between the optician and the optometrist and  
20 tell me what the training is of the optician and the distinction  
21 from the training you have for the optometrist?

22 MR. BAKER: Well perhaps to just go back over  
23 the ground a bit and draw a parallel, the position of the  
24 optician in the ophthalmologic field is very similar to the  
25 position of the pharmacist in the medical field. He is not an



247

1 Canadian Council of Physicians and Surgeons, 25 York Street,  
2 Toronto, Ontario, M5S 1A5. It is a body which is  
3 and all part of the public and professional interests in  
4 the medical profession for medical education and health  
5 services in the country, and the University of Toronto is  
6 a member of the Council. The University of Toronto is  
7 the principal institution of higher learning in  
8 the province of Ontario.

9 DR. GALLOWAY: If the patient is referred by  
10 the physician to the University of Toronto, would the  
11 plan be referred to the University of Toronto?  
12 MR. BAKER: No, I don't think the plan would

13 be referred to the University of Toronto. The University  
14 of Toronto is a body which is a part of the public  
15 and professional interests in the medical profession,  
16 and the University of Toronto is a member of the Council.

17 DR. GALLOWAY: Thank you very much.  
18

19 MR. WHITNEY: Mr. Chairman, this person called  
20 an optician, would you tell me more about an optician, giving  
21 me the distinction between the optician and the optometrist?  
22 Tell me what the training is of the optician and the distinction  
23 from the training you have for the optometrist?

24 MR. BAKER: Well perhaps to just go back over  
25 the ground a little and have a general idea of the  
26 distinction between the optician and the optometrist. The  
27 optician is a person who is a part of the public and



1 initiator of services. He complies with the instructions of  
2 either the optometrist or the ophthalmologist.

3 MR. WHITNEY: Is there any judgment in this  
4 regard so far as the training of the optician is concerned?

5 MR. BAKER: I am not sure of this. At one time,  
6 up to several years ago the optician was licensed under the  
7 Optometry Act and more recently, and I have forgotten the year  
8 but it is probably within the last three years, they have  
9 obtained their own statute and have set up their own training  
10 program.

11 When they were licensed under our Act, or con-  
12 trolled under our Act, the program, if my memory again serves  
13 me correctly, was an entrance requirement of Grade XII and I  
14 believe a year of training, or two years of training. Currently  
15 I have the impression that it is no more than that, and I would  
16 refer you directly to their licensing organization for more  
17 specific information but for the sake of trying to clarify this  
18 point here, I have the impression that it is now more or less  
19 on a home study apprenticeship type of training in this Province.  
20 Now specifically the duration of it, the ground covered, I am  
21 not sure but if my impression is correct, it tends to be on a  
22 home study apprenticeship type of program over a stated number  
23 of years.

24 MR. WHITNEY: Does the optician have the same  
25 right to offer his services in the market in the same way as the





either the optometrist or the ophthalmologist.

MR. WHITNEY: Is there any judgment in this

regarding the training of the optician?

MR. BAKER: I am not sure of this. At one time

in the several years ago the optician was licensed under the

University Act and some colleges, and I have forgotten the year

but it is probably within the last three years, they have

changed their status and have now been brought under the

Program.

When they were licensed under our Act, or com-

monwealth Act, the minimum of education was Grade XII and I

am correctly, was an entrance requirement of Grade XII and I

believe a year of training, or two years of training. Current

is now the minimum is Grade XII and I believe a year of training

or two years of training, depending on the province.

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Now specifically the duration of it, the ground covered, I am

not sure but my impression is correct, it tends to be on a

home study apprenticeship type of program over a stated number

of years.

MR. WHITNEY: Does the optician have the same

right to enter the profession in the same way as



1 optometrist? To invite people to come into his office or  
2 establishment and does he use the same machines to test the  
3 eyes?

4 MR. BAKER: He does not do any testing at all,  
5 if I may use your terminology. The fact is that his work does  
6 not begin until either the optometrist or the ophthalmologist  
7 initiates it by direction.

8 MR. WHITNEY: So we don't find him with a store  
9 on the street and a sign hanging out inviting people to come  
10 in?

11 MR. BAKER: Yes, we do. As a matter of fact,  
12 I would say that the majority of their establishments are of  
13 this nature.

14 MR. WHITNEY: Well if one ---

15 MR. BAKER: Very similar to the pharmacist.

16 MR. WHITNEY: Well if we did go in to the optician,  
17 what would he do to us?

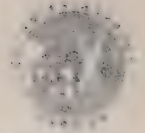
18 MR. BAKER: Well I think ---

19 MR. SIMON: Take your money for sure.

20 MR. BAKER: As a matter of fact, he might even  
21 give you some very good advice.

22 MR. WHITNEY: What services does he sell though.  
23 This is not a facetious question.

24 MR. BAKER: I recognize that. I think that what  
25 would occur is that if you walked in and said I think I have an



1  
2  
3 eyes?  
4 MR. BAKER: He does not do any testing at all.  
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6  
7 initiates it by disposition.  
8 MR. WHITNEY: So we don't find him with a nose  
9  
10 in?  
11 MR. BAKER: Yes, we do. As a matter of fact,  
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19 MR. SIMON: Take your money for sure.  
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21 give you some very good advice.  
22 MR. WHITNEY: What services does he sell through  
23 This is not a factious question.  
24 MR. BAKER: I recognize that. I think that what  
25





1 eye problem, he would say that is too bad but I would suggest  
2 you either consult your optometrist or your ophthalmologist  
3 and then when he does what he has to do, you come back and see  
4 me. I would be glad to do what has to be done then, and he  
5 would fill the prescription, or if you walked in with a broken  
6 lens and said I am in trouble, I have to go out of town, he  
7 would replace this broken lens but if you went in specifically  
8 to have an operation on your eye, as such, I think he would  
9 refer you, and rightly so and I think he would be pleased to  
10 do that, he would refer you either to the optometrist or the  
11 ophthalmologist to seek that type of service.

12 MR. WHITNEY: He doesn't do testing to tell you  
13 whether you need reading glasses?

14 MR. BAKER: That is right; nor does he want to,  
15 I understand.

16 MR. WHITNEY: You mentioned that there are, or  
17 someone mentioned that there are 2,600 cases taken care of  
18 somehow on the welfare plan basis. Do you people have any sort  
19 of a welfare plan operating similar to the O.M.A. welfare plan  
20 to take care of those people who are under the seven welfare  
21 Acts that are listed in this Bill? I am thinking of the  
22 totally indigent group now.

23 MR. LANGER: There is no formalized procedure,  
24 no, such as the Ontario Medical Welfare Plan. Most of these  
25 2,600 cases, that I referred to, would be cases where the



1 the President, the Secretary of Defense, the Secretary of the Navy, the Secretary of the  
2 the Attorney General, the Secretary of the Department of Justice, the Secretary of the  
3 the Department of the Interior, the Secretary of the Department of the Treasury, the Secretary of the  
4 the Department of Education, the Secretary of the Department of Health, Education and Welfare, the Secretary of the  
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6 lens and said I am in trouble, I have to go out of town, he  
7 would replace this broken lens but if you went in specifically  
8 to have an operation on your eye, he said, I take the  
9 return you, and rightly so and I think he would be pleased to  
10 do that, he would make you comfortable and I think he would  
11 ophthalmologist to seek that type of service.

12 MR. WHITNEY: He doesn't do testing to tell you

14 MR. LAMBER: That is right; now does he want to

16 MR. WHITNEY: You mentioned that there are, or

17 someone mentioned that there are 2,600 cases taken care of  
18 somehow on the welfare plan basis. Do you people have any sort  
19 of a welfare plan operating similar to the O.W.A. welfare plan  
20 to take care of these people who are under the seven welfare  
21 Acts that are listed in this Bill? I am talking of the  
22 totally indigent group now.

23 MR. LAMBER: There is no formalized procedure,

24 as far as the welfare plan is concerned, I think that  
25 is correct, that is correct, would it be correct to say that



1 Province has decided, for individual reasons involved in the  
2 individual, that assistance must be given and they assisted the  
3 person in receiving care from a private practitioner.

4           There are some provisions municipally for such  
5 assistance in Ontario, service clubs and practitioners, many  
6 local societies, for example offer the service of their  
7 practitioners to various social welfare groups so that referral  
8 is made and provision of necessary services is given on a  
9 basis heavily subsidized by the profession. In many cases only  
10 the cost of materials would be charged, and in many cases even  
11 that charge would be waived but no formal provision, no.

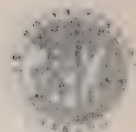
12           MR. ATTRIDGE: May I add to that Mr. Chairman?  
13 Remember I mentioned in my remarks we are very pleased to see  
14 vision care has been included in Bill 163 in order that the  
15 people in this bracket will at least have the care that they  
16 deserve and require.

17           MR. WHITNEY: I am quite clear on that. Would  
18 you give me a little further explanation as to what the  
19 ophthalmologist does, that you do and don't do? What is the  
20 difference again in these services? I am not clear on that.  
21 For instance, does he do surgery of the eye?

22           MR. LAMONT: Yes.

23           MR. WHITNEY: He goes on into various things like  
24 that. Of course, you don't. You simply diagnose some sort of  
25 a, whether you call it occlusion or cloudiness, or something





551

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There are some provisions municipally for such  
assistance in Ontario, but it is not  
total assistance, for example after the stroke of 1961  
provisions for various social welfare groups in each  
in case and provision of assistance is given in a  
basis partly dependent on the individual. In each case  
the form of assistance is different, and in some cases  
that change would be waived but no formal provision, no.

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MR. LAMONT: Yes.  
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MR. WHITNEY: He goes on into various things.  
MR. LAMONT: Yes. The ophthalmologist does not  
do surgery, but he does a great deal of work in the  
diagnosis and treatment of eye diseases.



wrong in there, and you would send him then over for medical attention?

MR. LAMONT: Yes.

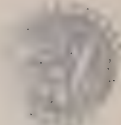
MR. ATTRIDGE: May I elaborate? The patient comes up to our office. The patient is examined. First the possibility of a pathological problem is definitely eliminated. If there is a sign that there is an incidence of pathology directly in the eye, or probably through the body, the patient is immediately referred to the proper practitioner. If it is in the eye, of course, it's to the ophthalmologist who is the man, and the only man capable of treating the medical aspects of the eye and also to perform all eye surgery. That is not our field. We do not want any confusion there whatsoever. We practise with the healthy eye. Once the fact that the eye is healthy has been established, then it is a matter of a motional problem; probably a matter of focussing of the eye, the co-ordination of the eyes. A matter of functional problem at any rate.

MR. WHITNEY: Where does the oculist fit into the picture?

MR. ATTRIDGE: The oculist and ophthalmologist are basically the same sir.

MR. BAKER: That is because most people cannot pronounce ophthalmologist.

MR. WHITNEY: That is a good reason. Now there



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MR. LAMONT: Yes.

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MR. BAKER: That is because most people cannot

pronounce ophthalmologist.

MR. WINTER: That is a good point, and I





1 has been mention of present plans. The difficulty that you  
2 see in Bill 163, is that the difficulty you are finding in  
3 present plans as well?

4 MR. LANGER: Most assuredly, with the exception  
5 of course of those plans which make provision for inclusion  
6 of optometrists.

7 MR. WHITNEY: Now in the services you are  
8 suggesting be included here, does this include the furnishing  
9 of the eye glasses as well as the diagnostic treatment?

10 MR. ATTRIDGE: No.

11 MR. BAKER: I think that our spokesman has said  
12 sir that we are not advocating any increase in the number of  
13 benefits to be provided under the Bill. The fact of the matter  
14 is that those services, which are related to the dispensing  
15 of ophthalmologic material, and the actual cost of the ophthalmologic  
16 material -- eye glasses -- are very clearly excluded in the  
17 Act as it now stands. There is no confusion in our minds about  
18 this at all.

19 MR. WHITNEY: So the excluding of eye glasses up  
20 in Section 3 of the exceptions in the draft schedule is all  
21 right. This doesn't cause you the difficulty. This is number  
22 eleven is it, the refractions?

23 MR. BAKER: No. It's the whole Bill.

24 MR. WHITNEY: I think that is all I have Mr.  
25 Chairman.



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of optometrists.

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1 THE CHAIRMAN: I would like to have further  
2 clarification on opticians. Are they licensed to perform  
3 refractions?

4 MR. BAKER: No.

5 THE CHAIRMAN: Therefore, if they do they would  
6 be doing an illegal act such as, for instance, a druggist if  
7 he diagnoses and prescribes would be doing?

8 MR. BAKER: He would run afoul of the Optometry  
9 Act and I don't know whether or not he might run afoul of the  
10 Medical Act as well.

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Act and I don't know whether or not he might run afoul of the

Medical Act as well.



1 MRS. AYLEN: On refractions your definition of  
2 that is for diagnosis only. Would that include prescribing?  
3 There would be an additional charge for prescribing?

4 MR. ATTRIDGE: The total fee of diagnosis --  
5 diagnosis and prescribing.

6 MRS. AYLEN: You stated that the regular cost  
7 scheduled fee is \$10.00 for refraction.

8 MR. ATTRIDGE: Refraction and prescription.

9 MRS. AYLEN: Would the average person have more  
10 than one examination per year?

11 MR. ATTRIDGE: No.

12 MRS. AYLEN: So you could say one examination  
13 every two years for the average person?

14 MR. ATTRIDGE: I think our figures on service  
15 have shown that it is every thirty-four months.

16 MRS. AYLEN: So that the financial hardship  
17 involved for any person if refractions were removed, would that  
18 average to about \$10.00 every thirty-six months?

19 MR. ATTRIDGE: Yes. We do not believe that you  
20 can disassociate refraction from other diagnostic services  
21 because, as has been stated, a person does not come and say I  
22 want a refraction because I want -- they still come with  
23 definite symptoms. For instance, supposing that a person were  
24 to attend one of the ophthalmologists and say, my eyes bother  
25 me in such and such a way. The only way we could find that out,



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6 MRS. AYLEN: You stated that the regular cost

7 scheduled fee is \$10.00 for refraction.

8 MR. ATTRIDGE: Refraction and prescription.

9 MRS. AYLEN: Would the average person have more

10 than one examination per year?

11 MR. ATTRIDGE: No.

12 MRS. AYLEN: So you could say one examination

13 every two years for the average person?

14 MR. ATTRIDGE: I think our figures on services

15 have shown that it is every thirty-four months.

16 MRS. AYLEN: So that the financial hardship

17 involved for any person if refractions were removed, would that

18 average to about \$10.00 every thirty-six months?

19 MR. ATTRIDGE: Yes. We do not believe that you

20 can disassociate refraction from other diagnostic services

21 because, as has been stated, a person does not come and say I

22 want a refraction because I want -- they still come with

23 definite symptoms. For instance, supposing that a person were

24 to attend one of the ophthalmologists and say, my eyes bother

25 me in such and such a way. The only way we could find that out





1 as to what to do, is to perform a refraction and therefore you  
2 think you can ---

3 MRS. AYLEN: I am not putting the ophthalmologist  
4 versus the optometrist.

5 MR. ATTRIDGE: I understand.

6 MRS. AYLEN: I am just trying to find out what  
7 the financial burden to the average person would be if refraction  
8 were removed from the bill as being eligible under the  
9 Bill. It would represent a hardship on the average of not more  
10 than \$10.00 every thirty-six months. Certainly not more than  
11 \$10.00 a year. In other words, a person would not go for an  
12 examination more than once a year. So, that \$10.00 a year per  
13 person would be about the financial hardship involved.

14 MR. BROAD: Where it would incur a hardship is  
15 for the one million two hundred thousand of low income.

16 MRS. AYLEN: Regardless of how many people, if  
17 you add that up in dollars for everything that benefits, it is  
18 a lot of money per person. Per person, it is a hardship of  
19 \$10.00.

20 MR. BROAD: Yes.

21 MISS CARPENTER: If a person starts with an  
22 optometrist and from an optometrist goes to an ophthalmologist,  
23 the plan would pay for two fees -- the initial fee would be of  
24 the optometrist, and he says no it is not that you need glasses,  
25 it is the ophthalmologist that you must see. If that person



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2 think you can ---  
3 MRS. AYLIN: I am not putting the ophthalmologist  
4 versus the optometrist.  
5 MR. ATTORNEY: I understand.  
6 MRS. AYLIN: I am just trying to find out what  
7 the difference is between the two. I am not  
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24 the optometrist, and he says no it is not that you need glasses  
25



1 goes on to an ophthalmologist, presumably there will be a  
2 second fee.

3 MR. BAKER: That is quite possible. The second  
4 fee would be for medical services, and in this respect it would  
5 not differ at all from the general medical practitioner  
6 referring a patient to a specialist after the patient has  
7 presented himself to the general practitioner. There is no  
8 difference in that relationship and in the relationship here  
9 either in the inter-practitioner relationship or the patient-  
10 practitioner relationship. It is not an unusual set-up in our  
11 scheme of things. I am now talking about the general health  
12 field. It does not create a peculiar situation.

13 THE CHAIRMAN: Dr. Butt?

14 DR. BUTT: I notice you were talking about the  
15 normal eye and also you talk about the diagnostic part of it.  
16 In other words, your eye care involved two aspects. And then  
17 you go on to campimetry. Could you give me an idea of what  
18 campimetry means with regards to diagnosis?

19 MR. BAKER: Campimetry is the investigation of  
20 the central field of vision. It is usually done on an instru-  
21 ment which is referred to as a tangent screen. A target is  
22 presented in the field of vision of each eye and the patient  
23 lets the practitioner know when he becomes aware of such a  
24 target. For this there are well known clinical standards.

25 In other words, the findings are well known as to





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1 what the normal is. What the optometrist is interested in is,  
2 does this patient respond to this test in a normal fashion.  
3 If he reacts to the test in an abnormal fashion, that is, the  
4 findings are not what the standards are, this simply means  
5 there is something wrong and the optometrist then refers him  
6 to the ophthalmologist who makes the diagnosis. It is a  
7 screening which is used -- the same technique as to whether  
8 that particular person and that particular eye responds in a  
9 normal manner.

10 DR. BUTT: What does tonometry mean?

11 MR. BAKER: The measurement of inter-ocular  
12 pressure.

13 DR. BUTT: Both these would have certain  
14 pathological findings if abnormal?

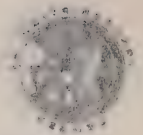
15 MR. BAKER: That is right. Just a matter of  
16 taking a scale reading. The standard is more or less establi-  
17 shed of what is considered to be a normal finding in the  
18 average eye. If the finding varies from this again, it is  
19 indicative that further investigation should be done.

20 DR. BUTT: To do all this, I believe, a tonometry  
21 would be taken, is this correct?

22 MR. BAKER: Yes.

23 DR. BUTT: What do you have to do to take the  
24 pressure -- put drops in the eye?

25 MR. BAKER: There are two ways of doing it. One



1 what the normal is. The question is answered by the  
2 fact that this patient's pressure is not normal. It is  
3 11 as regards to the fact that the normal pressure is  
4 12 mm. Hg. and the patient's pressure is 18 mm. Hg.  
5 There is something wrong with the patient's pressure  
6 as the normal pressure is 12 mm. Hg. It is a  
7 very high pressure. The normal pressure is 12 mm. Hg.  
8 and the patient's pressure is 18 mm. Hg. The patient's  
9 normal manner.

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16 degree of abnormality. The question is whether the

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1 is a newer development and will probably supersede the older  
2 one. A tonometry can be done on the sclera by using a standard  
3 schiotzometer, to use it on the sclera rather than on the  
4 cornea. When you use it on the sclera it can be used without  
5 any topical anaesthetic.

6 Newer development in that field has been pre-  
7 vented by massive costs and we are beginning to see a breaking  
8 through of the electronic tonometer, and it is being applied  
9 to the cornea without anaesthetic.

10 It is a matter of time until science catches up  
11 with us and gives us another newer and better method.

12 DR. BUTT: This is all what you feel is diagnostic  
13 services?

14 MR. BAKER: Yes, and we do it.

15 DR. BUTT: Refraction is merely getting glasses  
16 to suit the particular eye?

17 MR. BAKER: Refraction is again actually a  
18 sequence of events, if I may just expand on it, in which we  
19 are investigating the optical, the motor and sensory function  
20 of the eyes.

21 The most commonly known to people is either  
22 far or short-sighted astigmatism and presbyopia. This is what  
23 refraction means.

24 It really does not mean this in this field nor  
25 the field of ophthalmology. It is a sequence of tests that



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23 It really does not mean this in this field nor



1 actually establish the pattern of binocular and monocular vision  
2 and bases its investigations on the optical, the motor and the  
3 sensory aspects of vision.

4 DR. BUTT: You do not use any drugs at all in  
5 order to take your tonometry?

6 MR. BAKER: That is right.

7 DR. BUTT: One other thing that I was wondering  
8 about a little bit and maybe you can tell me. It is 26 of  
9 your Effect of Bill 163 on Student Recruitment.

10 "If, as a result of legislation, too few students  
11 are available or the quality of applicants  
12 lowered, how will the Government justify the  
13 part which its decisions have played in the  
14 loss of service to the public."

15 Can you give me any idea of the number of  
16 optometrists there were ten years ago and now in Ontario?

17 MR. BAKER: We have a Royal Commission brief.  
18 I would say there are approximately the same. There is not a  
19 wide variation.

20 DR. BUTT: Would you disagree with me when I  
21 say I have for 1956 665 and for the present time 548. Is that  
22 wrong?

23 MR. LANGER: Yes. I have 165 at no time.

24 DR. BUTT: I said 665.

25 MR. BAKER: That may be right.





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1 DR. BUTT: Those are correct?

2 MR. BAKER: Yes.

3 DR. BUTT: As far as students are concerned in  
4 the United States, in 1951 there were 2,015 registered, and in  
5 1961 1,422. In other words, to be quite frank I do not feel  
6 that this Bill as such would indicate recruitments of students.

7 MR. LANGER: Perhaps I could explain the figures  
8 you are quoting. The 1951 figures represent an enormous influx  
9 of post-war students. Therefore, you will find that the average  
10 number of students at that time was considerably higher than  
11 in 1960.

12 Now we find the situation, our experience at the  
13 College of Optometry that the curve following the period of  
14 1947 to 1952, let us say, at which time we would have perhaps  
15 three times the ordinary number of students in our classes.

16 Immediately following that period, there is a  
17 drop, in effect, of what perhaps existed. There is somewhat  
18 of an over supply; and the curve now is reversed and is passing  
19 into the same situation on all professions -- there are numerous  
20 students knocking at the door and our facilities are inadequate  
21 to train the number who come to us.

22 We have indicated before to the Royal Commission  
23 that our needs with respect to students would double by 1980,  
24 and our present facilities would not permit us to meet those  
25 needs.



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1 I think our point here is obviously if there are  
2 factors operating in the field of practice which inhibits  
3 patients visiting optometrists, this is going to make the field  
4 less attractive to qualify students.

5 DR. BUTT: These factors have happened. You  
6 can explain them as a scholastic situation.

7 When you get the Tables, I think there are  
8 ophthalmologists doing refractions, and then quote a figure of  
9 224 as of November 1963 which I believe disagrees with your  
10 figures.

11 MR. LANGER: I believe our figures were obtained  
12 from the College of Physicians and Surgeons.

13 DR. BUTT: Those were certified?

14 MR. LANGER: Those were certified ophthalmologists

15 DR. BUTT: Those are different from those who  
16 are doing refractions?

17 MR. LANGER: This is difficult to establish.

18 DR. BUTT: There are these other figures, in all  
19 fairness should be taken into consideration because they have  
20 been trained and perhaps not completed their five-year post-  
21 graduate work to obtain their certificate as such.

22 MR. LANGER: We did try to establish a figure to  
23 include that. Our Table I believe, as the Table the Association  
24 has presented, has tried to indicate certified and non-certified.

25 DR. BUTT: This was just another figure I



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1 happened to have.

2 THE CHAIRMAN: Mr. Major.

3 MR. MAJOR: Gentlemen, I would like to take a  
4 little different approach on this and as a citizen determine  
5 what my position is. I'd like to start off this way, that as  
6 a citizen if I attend an optometrist for a refraction or eye  
7 examination, would it be reasonable for me to expect with that  
8 examination to give me the full picture of my eye condition?  
9 Is it possible that through drugs or psychoplegics you can  
10 determine pathological conditions that cannot be determined  
11 without them?

12 MR. BAKER: I think you have two questions  
13 there. The answer to the first question is, yes.

14 The answer to the second question is that so  
15 far as we are concerned and so far as any studies that have been  
16 made, there is no great disadvantage in terms of spotting the  
17 abnormal from the normal -- of spotting the abnormal and normal  
18 without the use of drugs. I think the very fact that optometry  
19 exists on the strength it does that it is a world-wide pro-  
20 fession that is licensed to practise in this field all over  
21 testifies to the fact that the public is well protected in this  
22 and there is an area of responsibility and competence as has  
23 been demonstrated over the years.

24 The pattern is well set so far as North America  
25 is concerned and Great Britain. If you go to the United Kingdom





MR. MAYOR: Gentlemen, I would like to take a little different approach on this and as a citizen determine what my position is. I'd like to start off this way, that as a citizen if I attend an optometrist for a refraction or eye examination, would it be reasonable for me to expect with that examination to give me the full picture of my eye condition? Is it possible that through drugs or pathologies you can determine pathological conditions that cannot be determined without them?

MR. BAKER: I think you have two questions there. The answer to the first question is, yes. The answer to the second question is that as far as we are concerned and as far as any studies that have been made, there is no great disadvantage in terms of spotting the abnormal from the normal -- of spotting the abnormal and normal without the use of drugs. I think the very fact that optometrists on the strength it does that it is a world-wide profession that is licensed to practice in this field all over testifies to the fact that the public is well protected in that and there is an area of responsibility and competence as has been demonstrated over the years.

The pattern is well set as far as North America



1 you will find under the National Health Scheme there that  
2 optometrists by far do the largest proportion of the work --  
3 somewhere between 80 and 85% of the total of the work in this  
4 field.

5 MR. MAJOR: That is less than one available for  
6 100,000 people in the United Kingdom?

7 MR. BAKER: I do not know what the reason is.  
8 I can tell you what is happening.

9 This development has taken place -- I am talking  
10 about academics and not utilization in Australia and New Zealand  
11 and so forth. I want to get it out of the context that may be  
12 implied here, not suggesting what you are implying can be  
13 misinterpreted -- it is a rather local situation. Optometry  
14 exists all over. It is there and it has been for many years.  
15 I think all I can say to you is when we developed the scheme  
16 in the Royal Commission, it was because this kind of question  
17 was asked. There is very little doubt of the optometrist's  
18 ability to carry out this responsibility.

19 I think that our present relationship with  
20 ophthalmologists indicate that this actually operates. There  
21 is no problem, I am sure. We make a number of mistakes but I  
22 think they are legitimate mistakes. The fact of the matter is  
23 that by and large there is no problem here. There is no  
24 necessity for any reticence on the part of anyone.

25 MR. MAJOR: Supposing, and I am not a doctor nor



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necessity for any residence on the part of anyone.  
MR. MAJOR: Supposing, and I am not a doctor





1 am I an optometrist but I am in the business of medical insur-  
2 ance and this is the way we think in terms of living --  
3 supposing that a citizen has an eye examination by an optome-  
4 trist and that examination missed some stomach or metabolic  
5 condition, would the optometrist have any legal responsibility?





1 MR. BAKER: In this province I believe the  
2 answer would be no.

3 MR. MAJOR: He wouldn't. I think that came to  
4 mind because of the ratio of ophthalmologists, if my memory  
5 serves me right, I believe the World Health Organization set  
6 up standards attempting to arrive at the standard of ophthal-  
7 mologists, I am talking about certificated medical  
8 practitioners per one hundred thousand population. In the  
9 United States I think that figure ran three ophthalmologists.  
10 In the United States that figure runs about 3.3, and I am  
11 quoting from memory again, in Ontario the figure runs  
12 approximately two, between 2.5 and 2.6, so that I am tempted  
13 to question this so-called lack of ophthalmological services  
14 to the public. It may be a matter of getting it properly  
15 spread around geographically.

16 MR. BAKER: Is that a question?

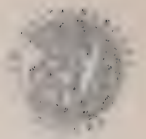
17 MR. MAJOR: No, I am speaking of a fact. We  
18 have heard of this lack. You stated two or three times that  
19 there wasn't enough ophthalmologists to do the job. We are  
20 very close according to the World Health Organization standards.  
21 How fast we will need them, that I don't know.

22 MR. LANGER: Could I comment on that?

23 MR. MAJOR: Sure thing.

24 MR. LANGER: I believe that first of all there  
25 are a number of figures that are of interest here. That is the





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1 figures that are available indicate utilization of vision care  
2 services in Canada of approximately 13.2% of the population  
3 per year. As I understand the utilization figures from  
4 programs such as Windsor Medical and P.S.I, the utilization of  
5 vision care services under these programs is about 6%, between  
6 five and six per cent.

7 MR. MAJOR: That would be approximately right.  
8 It wouldn't be more than six.

9 MR. LANGER: It seems to me with these programs,  
10 eye vision care is exclusively provided by ophthalmologists  
11 and I think a subscriber that is covered for this service  
12 presumably will utilize it. The fact that the utilization  
13 under this program is considerably less than the utilization  
14 of the general population indicates the ophthalmologist is  
15 unable to provide the service to all that require it. Certainly  
16 with respect to geographical distribution I don't think it  
17 could be disputed that it is impossible for ophthalmologists  
18 to provide services. I don't think we are suggesting there is  
19 a shortage of ophthalmologists but we are suggesting that  
20 vision care services which is optometrical requires an optometrist  
21 to perform. This is perhaps the different attitude between our  
22 attitude and your attitude.

23 MR. MAJOR: Have optometrists thought of  
24 developing any travelling clinics? In other words optometrists  
25 are not in every geographical area of the province. Is there



1. Figure 1 shows the estimated number of people who  
2. receive in excess of approximately 15% of the population  
3. per year. As I understand the situation, it is  
4. program was an initial phase and I think the estimated  
5. vision care services would be provided in about 15, 20 years  
6. five and six per cent.

7. MR. MAJOR: That would be approximately right.  
8. It wouldn't be more than six.

9. MR. LANGER: It seems to me with these programs  
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13. is necessary is a necessary part of the subscription  
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18. to provide services. I don't think we are suggesting there is  
19. a shortage of ophthalmologists but we are suggesting that  
20. vision care is not being provided in a timely manner  
21. in certain areas. The situation is not the same in all  
22. attitude and your attitude.

23. MR. MAJOR: Have ophthalmologists thought of  
24. developing any special clinics for their own patients?  
25. and not in very specialized areas of the program, as I have





1 any thought of taking these people in there on a travelling  
2 clinic basis?

3 MR. LANGER: There is a great deal of that in  
4 existence at the present time where a practitioner might,  
5 perhaps, arrange to have a clinic in the community one day  
6 a week or a month in order to provide services to an area  
7 which isn't serviced by a practitioner.

8 MR. MAJOR: The ophthalmologists are doing the  
9 same thing?

10 MR. LANGER: I believe the ophthalmologists are  
11 doing the same thing.

12 MR. MAJOR: There is a strong attempt being made  
13 by both professions to cover these so-called non-covered  
14 districts through travelling clinics.

15 MR. BAKER: There is also recognition of this  
16 in the Junior Red Cross. They have a vision care program and  
17 it is staffed by optometrists who cover the north country during  
18 the school season.

19 MR. MAJOR: Tell me, do you put much value in  
20 the Snellon Test?

21 MR. BAKER: If you could explain to me what you  
22 mean by that?

23 MR. MAJOR: The Snellon Test is some kind of  
24 chart whereby you determine whether any person, child or adult,  
25 particularly a teenager rather than a small child, can read



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1 certain classifications of letters?

2 MR. BAKER: Yes. Trying to answer the question  
3 in this context, it is probably the best single test for  
4 screening, the best single test, but it has inherent in it two  
5 problems, it both under and over refers. I am not sure of my  
6 statistics on this, but they are significant. There has been  
7 enough work done in this field in terms of screening where it  
8 has been proven beyond any doubt at all that total reliance  
9 on this test is not particularly desired.

10 MR. MAJOR: It will give you a signal as to the  
11 next milestone?

12 MR. BAKER: It gives you part of the signal but  
13 it can also mask a problem. It both under and over refers.  
14 The biggest problem is one of under-referrment. All vision  
15 problems are not related to visual acuity at that distance.

16 MR. MAJOR: In other words use of this kind of  
17 test in outlying districts is questionable but it could be  
18 handled by the general practitioner in medicine?

19 MR. BAKER: Well, it is, isn't it?

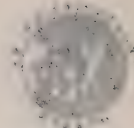
20 MR. MAJOR: Not necessarily.

21 MR. BAKER: I think I am trying to interpret  
22 what you are pointing to is that in fact someone else could  
23 detect this problem.

24 MR. MAJOR: Up to a point.

25 MR. BAKER: That is the direction of the question?





MR. BAKER: Yes. Trying to answer the question

screening, the best single test, but it has inherent in it two problems, it both under and over refers. I am not sure of my

has been proven beyond any doubt at all that total reliance on this test is not particularly desired.

MR. MAJOR: It will give you a signal as to the

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problems are not related to visual acuity at that distance.

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test in outlying districts is questionable but it could be

MR. MAJOR: Not necessarily.

MR. BAKER: I think I am trying to interpret

MR. MAJOR: Up to a point.

MR. BAKER: That is the direction of the ques-



1 MR. MAJOR: That is right. What I am endeavouring  
2 to do is to come to this, it is pretty nigh impossible to  
3 provide professional people, and I am going to talk about  
4 medical people around the province, neurologists, ophthalmolo-  
5 gists, the specialist, the highly trained specialist with  
6 twelve or thirteen years behind them of training and it has  
7 become the order of the day or is becoming the order of the day  
8 to have set up travelling clinics or bring these people to the  
9 centre. What we really need in these districts is a reasonable  
10 screening process to get them here; isn't that right?

11 MR. BAKER: Well, with all due respect we are  
12 talking here about two things. First of all if you got the  
13 trained manpower, and you will concede optometrists are trained  
14 manpower why single them out, why not include them. This only  
15 makes the problem more serious, no matter what side of the  
16 fence you want to sit on. I think the remarks I made to  
17 Miss McArthur apply here. We are talking about Bill 163 and we  
18 are talking about the benefits that are in Bill 163. It seems  
19 to me and this is one of the things that we pointed out, and  
20 perhaps didn't express too clearly in our Toronto Optometrists'  
21 brief, we are talking here of what we consider to be at least  
22 a social change in which third party groups now come into health  
23 care and you are representing one of these third party groups.  
24 What we are saying is that you have, and I don't mean you as an  
25 individual, the third party groups have a responsibility in the



MR. MAJOR: That is right. What I am endeavouring

to do is to point out to you that the order of the day is becoming the order of the day for the people to have set up travelling clinics or bring these people to the centre. What we really need in these districts is a reasonably

twelve or thirteen years behind them of travelling and it has become the order of the day or is becoming the order of the day to have set up travelling clinics or bring these people to the centre. What we really need in these districts is a reasonably

MR. BAKER: Well, with all due respect we are talking here about two things. First of all if you got the trained manpower, and you will concede optometrists are trained manpower why single them out, why not include them. This only

makes the problem more serious no matter what side of the fence you want to go. I think the remarks I made to Mrs. McArthur apply here. We are talking about Bill 103 and we are talking about the benefits that are in Bill 103. It seems

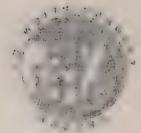
to me and this is one of the things that we pointed out, and perhaps didn't express too clearly in our Toronto Optometrists' brief, we are talking here of what we consider to be at least a social change in which third party groups now come into play

and you are representing one of these third party groups. The third party groups have a responsibility in the





1 field because health care in this province has developed a  
2 certain pattern. It may not be the best pattern, but it has  
3 developed a certain pattern which has met many of the needs  
4 that the public have. What this has done, and P.S.I. has  
5 contributed to this so far as this field is concerned is that  
6 in offering a refraction benefit in these contracts, which  
7 particularly in some of the areas it has sold, it can't  
8 possibly fulfil its obligation. All I am saying here and I  
9 think this is the pertinent thing in terms of Bill 163 is that  
10 in these very places where these services are being sold and  
11 not available under that contract the fact is there are  
12 optometrists and the public has to make a choice of either  
13 going outside their program and paying for these services  
14 themselves, but if they have already paid in your contract  
15 they wait for somebody to get an automobile or a van and come  
16 from where they live to another centre in order to obtain the  
17 services of the program. The fact is that this thing operates.  
18 There are optometrists that look after the bulk of the vision  
19 care services and talking of the World Health Organization,  
20 I am not familiar with their figures, but I think it is  
21 medically orientated on the number of ophthalmologists required  
22 to look after the medical and surgical needs of this public  
23 rather than the vision care needs because that is their  
24 emphasis, and I think they would agree with this. The fact  
25 of the matter is that the whole world is flooded with statistics.



1 their income relative to the average has decreased in  
2 certain periods. It may not be the best picture, but it is  
3 developed a certain picture which can be used in many  
4 cases the public have. When this was done, and P.O.D. was  
5 contributed to this as far as this is concerned in this  
6 in offering a collection period in these respects, which  
7 particularly in case of the time it has said, it can't  
8 possibly tell its collection. All I am saying here and I  
9 think this is the nearest thing in terms of what is said  
10 in these very places where these services are being said and  
11 not available under that contract the fact is there are  
12 operators and the public has to make a choice of either  
13 being satisfied with the program and paying for these services  
14 themselves, or if they have already paid in past contracts  
15 they will have money to get an automobile or a car and some  
16 from some day live in another house in order to obtain the  
17 services of the program. The fact is that this thing operates  
18 years ago and it has been said that after the end of the 1960s  
19 was reached and failed at the public organization.  
20 I am not familiar with their figures, but I think it is  
21 actually estimated on the number of organizations that  
22 in fact after the public and private needs of this public  
23 system than the public rate needs because that is what  
24 happens, and I think they would agree with this. The last  
25 of the matter is that the whole world is becoming a statistic



1 We know how many people seek these services and we know that  
2 optometrists serve most of us. I think we must go on the  
3 basis of what exists. There is no need for theorizing on  
4 this.

5 MR. MAJOR: P.S.I. sales contract, the legal  
6 contract?

7 MR. BAKER: Right.

8 MR. MAJOR: Bill 163 is determined to become  
9 a legal contract. As Bill 163 is presently set up this contract  
10 covers services of licensed medical practitioners known as  
11 physicians. This is the fundamental point here. If you bring  
12 into this Bill that you have now discussed all the health  
13 services that should be brought in whether they are diagnostic  
14 or not, where do you place the optometrist in respect to the  
15 oral surgeon and the podiatrist and nurses. If I was in bed  
16 with a case of pneumonia do I want to have sitting beside me  
17 a nurse or an optometrist?

18 MR. BAKER: I would choose a nurse.

19 MR. MAJOR: What we are talking about is not  
20 relevant in the wording of this Bill because this Bill is a  
21 physician service.

22 MR. BAKER: No.

23 MR. MAJOR: It has nothing to do with optometry,  
24 nothing to do with podiatry, nothing to do with dentistry, it  
25 has nothing to do with nursing.





1. The Board of Regents of the State University of the State of New York  
2. has adopted a resolution which provides that the Board of Regents  
3. shall have the right to appoint and remove members of the Board of Regents  
4. of the State University of the State of New York.

5. MR. MAJOR: P.S.I. sales contract, the legal  
6. contract?  
7. MR. BAKER: Right.

8. MR. MAJOR: Will it be necessary to have  
9. a contract? As I said, it is necessary to have a contract  
10. covers services of licensed medical practitioners known as  
11. optometrists. It is in the Contractual Code Book. It is in the  
12. into this Bill that you have now discussed all the health  
13. services that are in the Contractual Code Book and also  
14. in the Contractual Code Book. It is in the Contractual Code Book  
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17. a nurse or an optometrist?

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19. MR. MAJOR: What we are talking about is not  
20. relevant in the wording of this Bill because this Bill is a

21. Bill to amend the Contractual Code Book.  
22. MR. BAKER: No.

23. MR. MAJOR: It has nothing to do with optometry  
24. has nothing to do with nursing.



1 THE CHAIRMAN: It is not entitled that way. It  
2 is the Medical Services Insurance Act. It doesn't say physician  
3 service.

4 MR. MAJOR: Then it is necessary to define a  
5 physician.

6 MR. SIMON: It is not yet defined. That is why  
7 we are here.

8 MR. WHITNEY: To be fair, Mr. Major is referring  
9 to the Bill as it now stands. This doesn't say the Bill as it  
10 now stands is going to be the final form recommended by this  
11 Enquiry. I don't think we should spend any more time on these  
12 areas.

13 MR. MAJOR: If we are going to recommend on an  
14 undiscriminatory basis to include diagnostic services of the  
15 paramedical people being qualified by training or by inference  
16 that they may help out the situation by diagnostic services,  
17 then we have to include a lot more than the optometrical  
18 profession.

19 MR. WHITNEY: That is our problem.

20 MR. MAJOR: If you find an optometrist who is  
21 not practising according to your standard of ethics can you  
22 cancel the licence or commission or whatever it is? Have you  
23 power to control this man?

24 MR. BAKER: Yes.

25 MR. MAJOR: Do you do it?



THE CHAIRMAN: It is not entitled that way. It

service.

MR. MAJOR: Then it is necessary to define a

physician.

MR. SIMON: It is not yet defined. That is why

we are here.

MR. WHITNEY: To be fair, Mr. Major is referring

to the Bill as it now stands. This doesn't say the Bill as it

was originally passed, but as it stands, the Bill as it

stands. I am not sure if that is what you are referring to.

status.

MR. MAJOR: If we are going to recommend an

amendmentary basis to include diagnostic services of the

paramedical staff, we are going to have to make it clear

that they may help out the situation by diagnostic services.

then we have to include a lot more than the optometrical

profession.

MR. WHITNEY: That is our problem.

MR. MAJOR: If you find an optometrist who is

not qualified to do that, you can't have him do it.

cancel the licence or commission or whatever it is? Have you

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1 MR. BAKER: Yes.

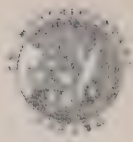
2 MR. MAJOR: During the questions you stated that  
3 if you sent a patient, if you decided a patient should go to  
4 an ophthalmologist it would take from two to three months for  
5 this patient to get to the ophthalmologist?

6 MR. BAKER: That is not correct, sir.

7 MR. MAJOR: Did I misinterpret it?

8 MR. BAKER: I don't know whether you misinter-  
9 preted it but I can certainly clarify it. The question I was  
10 asked was how busy were the ophthalmologists, and that was the  
11 answer. The fact of the matter, though, is the relationship  
12 between the optometrist and the ophthalmologist. It is such  
13 that we generally will say to a patient we think that you need  
14 medical consultation. Generally speaking the patient will say  
15 who should I go to, that is pretty typical to the health care  
16 field. You may tell them one or two or three names of  
17 ophthalmologists and they will say this one is in my district,  
18 can we see him. Generally it is a matter of picking up the  
19 telephone then and speaking to Doctor So-And-So and saying,  
20 Doctor, I have a suspicion of this, and he will say I will see  
21 him tomorrow. There is no problem.

22 MR. MAJOR: That is what I wanted. I see the  
23 examination fee, \$10.00. You talk about special procedures,  
24 tenometry and something else. Is this included in your \$10.00  
25 fee or is it straight refraction and so on?



MR. BAKER: Yes.

MR. MAJOR: During the questions you stated the

if you sent a patient, if you decided a patient should go to

this patient to get to the ophthalmologist?

MR. BAKER: That is not correct, sir.

MR. MAJOR: Did I misinterpret it?

MR. BAKER: I don't know whether you misinter-

preted it or not, but I am sure that I am sure I am

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MR. MAJOR: That is what I wanted. I see the

examination fee, \$10.00. You talk about special procedures,

and then you talk about special procedures, and then you talk about

fee or is it straight refraction and so on?



1 MR. BAKER: It is generally included.

2 MR. MAJOR: It includes all the special things,  
3 refraction -- your eye examination is a wrap-up?

4 MR. BROAD: We consider it.

5 MR. MAJOR: In the milestones of examination as  
6 you go along these would also be included?

7 MR. BROAD: Yes.

8 MR. MAJOR: You say you have a fee schedule.  
9 Would it be possible for your organization to forward to the  
10 Chairman of this Enquiry a copy of that fee schedule with the  
11 procedures that you feel should be covered in Bill 163  
12 identified.

13 MR. DUFFY: Yes.

14 MR. MAJOR: Because we will be likely studying  
15 that question.

16 MR. LANGER: Sir, there is one point here, and  
17 this is, of course, we don't to restrict or to have the  
18 appearance of restricting the service. Our basic contention  
19 is made on principle, any service we are legally and academically  
20 qualified to perform which are provided for in Bill 163 should  
21 be available from optometrists, and therefore we wouldn't wish  
22 to be in the position of having a type of particular procedure.

23 MR. MAJOR: It is only incidental to help us.  
24 The same procedure has been put before this Enquiry by the  
25 oral surgeons and podiatrists, exactly the same thing. Mr.





It is generally included.

MR. MAJOR: It includes all the special things.

retraction -- your eye examination is a wrap-up?

MR. BROAD: We consider it.

MR. MAJOR: In the milestones of examination and

you go along these would also be included?

MR. MAJOR: You say you have a fee schedule.

Will it be possible for your committee to conduct an

examination of this body of work to see if there is

procedures that you feel should be covered in Bill 103

identified.

MR. MAJOR: Because we will be likely studying

MR. LANGER: Sir, there is one point here, and

this is, of course, we don't to restrict or to have the

appearance of restricting the service. Our basic conception

is to have the service, and we want to see if there is

any of the service that we want to see if there is

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MR. MAJOR: It is only incidental to help us.

The same procedure has been put before this body by the

and we want to see if there is any of the service that



1 Chairman, I think that answers my questions.

2 THE CHAIRMAN: Mr. Naylor.

3 MR. NAYLOR: In answer to Mr. Coulter's question  
4 you stated some very good argument against omitting eye  
5 refractions from the Bill. However, on the other hand there  
6 are some things I have been wondering, looking at the Bill from  
7 an insurance point of view, whether the expense of refractions  
8 should be included. For one thing as Dr. Hagey brought out  
9 the financial hardship arising from this expense is not too  
10 great on any one person. A further point is that I believe  
11 that this service is to some extent elective, at least the  
12 frequency of its use is elective. Would you agree with that?  
13 Would you agree that there would probably be increased usage  
14 on this if it were insured? Have you any suggestions? Do you  
15 feel that limitations to help control this would be desirable?  
16 Have you any suggestions as to what limitations might be  
17 appropriate?

18 MR. BAKER: If I may be permitted to begin  
19 answering the question. The experience, the only experience  
20 I can go to is the question of controls and abuses by either  
21 the practitioner or the public. The fact of the matter is that  
22 when the benefit is set on the program for a good deal of time,  
23 and the only reference I have for making this statement is the  
24 National Health Services, the fact is that it has flattened out  
25 and stayed, the utilization rate has stayed somewhere around 13%.



Chairman, I think that answer is sufficient.

THE CHAIRMAN: Mr. Naylor.

MR. NAYLOR: In answer to Mr. Coulter's question

you asked some very good questions about the

relationship between the Bill, Chapter, on the other hand, there

are some things I have been wondering, looking at the Bill in

an attempt to get at what, whether the scope of the

scope is limited, but you said as Mr. Baker pointed out

the financial savings arising from this expense is not too

great on any one person. I thought there is that I believe

that this system is in some cases effective, at least the

operation of it is in effect. Would you agree with that?

Would you agree that there would be increased costs

in this if it were necessary to have any responsibility? Do you

feel that it is necessary to have control over what is necessary

have the responsibility as to what limitations might be

appropriate?

MR. BAKER: If I may be permitted to begin

summarizing the question, the expenses, the only expenses

I can go on in the question of liability and extent of expenses

the question of the liability. The fact of the matter is that

there the benefit is not on the other side of the coin of the

and the only reference I have for this is the statement in the

National Health Insurance Act in that it has been found that

and again, the utilization of the Bill, Chapter, Chapter, Chapter





1 There was an upper rate, and that was several years ago, about  
2 two years, if my memory serves me correctly. The greatest rate  
3 I believe they have hit was 20% utilization and it dropped  
4 back. Incidentally, there, you know they supply everything,  
5 everything in the way of ophthalmic material. The experience  
6 there indicates that particular benefit is not abused generally.  
7 There is a pattern. It has been going for years and running  
8 somewhere around 13%. There is one peaking and that was it.

9 So far as the procedure, it is partly elective.  
10 It is not always elective, and I say that because in my  
11 practice, for example, there is hardly a day or a week that  
12 goes by that little Johnny or Jane doesn't come in with a slip from  
13 the school nurse saying he can't or she can't see the black-  
14 board, and in this sense it is not elective. Once the treatment  
15 is begun to a large extent it does become elective, there is  
16 no doubt about that, so there are many aspects to it. I think  
17 that the feeling of the group, and I stand to be corrected by  
18 my group, is that on the average the routine check-up can be  
19 properly limited to once every two years.

20 There might be special cases, but they tend to  
21 be the exception rather than the rule and whether or not they  
22 can be handled, I think this is a matter of conference and  
23 discussion as this comes in. Of course, as you know, any one  
24 of our recommendations - the only way to get many of these  
25 problems, technical problems smoothed out, administrative



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discussion as this comes in. Of course, as you know, any one  
of our recommendations - the only way to get many of these



1 problems smoothed out is actually bringing in the groups that  
2 are involved and sit down. We hope we are reasonable people  
3 and there is no reason why these things can't be worked out.  
4 I don't know all the controls. I am sure that controls are  
5 available against abuses and all the other things. I cannot  
6 add any more to my remarks.

7 MR. LEMONT: I would like to pursue this, if I  
8 may. First of all, this question of being elective, I should  
9 like to point out is true of many many services that are  
10 covered under the Medical Services Act and, therefore, I do  
11 not think is germane to single out vision care service as  
12 being something different.

13 Many services are elective and you might,  
14 therefore, argue could be left out. Similarly, many services  
15 involve a small expense to the individual that could be left  
16 out. Surely what we are talking about here today is not  
17 catastrophic insurance but comprehensive coverage.

18 On that basis it seems to me the public has  
19 demonstrated, quite conclusively, that this is what they are  
20 seeking: Comprehensive services which would involve first call  
21 visit, from first visit and all aspects of services that are  
22 required.

23 Now even with respect to this question of small  
24 financial burden, I can tell you certainly from personal  
25 experience in my office that while that figure of \$10 does not





278

1 I have been asked to do a lot of things in the past  
2 and I have been asked to do a lot of things in the past  
3 and I have been asked to do a lot of things in the past  
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5 available against abuses and all the other things. I cannot  
6 add any more to my remarks.

7 MR. LAMONT: I would like to pursue this, if I  
8 may. First of all, this question of being effective, I should  
9 like to point out is true of many many services that are  
10 covered under the Medical Services Act and, therefore, I do  
11 not think it germane to single out a vision care service as  
12 being something different.

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15 involve a small expense to the individual that could be left  
16 out. Surely what we are talking about here today is not  
17 catastrophic insurance but comprehensive coverage.

18 On that basis it seems to me the public has  
19 a right to expect that the services which would involve financial  
20 strain, from first visit and all aspects of services that are  
21 required.

22 Now even with respect to this question of financial  
23 burden, I can tell you certainly from personal  
24 experience that the financial burden is not the only one.



1 represent a considerable burden to the average person, certainly  
2 for the group, particularly I can think of old age pensioners,  
3 many old age pensioners have made statements in my office to  
4 the effect that well do I have to come back for a second  
5 visit? That means an extra car ticket and so this matter of  
6 expense is relative, certainly, and I think it is not incon-  
7 siderable to many people because, particularly with respect  
8 to the old age pensioners the incidence and utilization of  
9 this group would be high, and of course, similarly the family  
10 group in which a number of members of the family require eye  
11 care the cumulative cost could represent a substantial pro-  
12 portion of the health care budget for that family, so I think  
13 it is a mistake to single out vision care service as being  
14 something different from the other services which are covered  
15 in the program.

16 I think that we naturally think of the large  
17 expense involved in long, serious illnesses but most of the  
18 coverage provided under this plan is for services of exactly  
19 the same nature which may be elective and have a small cost  
20 for the individual.

21 MR. MAJOR: May I follow this up in this manner--

22 THE CHAIRMAN: Were you finished Mr. Naylor?

23 MR. NAYLOR: Not actually. I was just going to  
24 complete this particular point. I think you have answered the  
25 question very fully. Do I take it then that if it were



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the same nature which may be elective and have a small cost  
for the individual.

MR. MAYOR: May I follow this up in this manner?

THE CHAIRMAN: Were you finished Mr. Mayor?

MR. MAYOR: Not actually. I was just going to  
question very fully. Do I take it then that if it were





1 considered that this should be included that some limitation  
2 should be put on it? Perhaps an appropriate limitation might  
3 be one every twenty-four months.

4 MR. BAKER: Yes.

5 MR. NAYLOR: That is fine.

6 THE CHAIRMAN: Mr. Major?

7 MR. MAJOR: Following through your thinking sir,  
8 as a citizen would you rather have a comprehensive health  
9 service with the \$50.00 deductible against it to start something  
10 off, or would you rather have this health coverage on a limited  
11 basis to start it off?

12 THE CHAIRMAN: You can only answer this as a  
13 personal opinion rather than as an opinion from your Association.

14 MR. MAJOR: I asked him as a citizen.

15 THE CHAIRMAN: If you wish to answer it.

16 MR. ATTRIDGE: I think that would require  
17 considerable thought. I wouldn't want to answer that on a  
18 snap judgment.

19 THE CHAIRMAN: Any further questions? Mr. Simon?

20 MR. SIMON: If the demand on the part of the  
21 public for vision care has increased in recent years, and  
22 whether the fact of more and more people living in urban areas,  
23 under the stress and emotion of modern day living, television  
24 and so on, have you studied any effect of this increased demand?

25 MR. BAKER: I think this has had this effect sir:



1  
2 should be put on it? Perhaps an appropriate limitation might  
3 be one every twenty-four months.  
4  
5 MR. MAYOR: That is fine.  
6 THE CHAIRMAN: Mr. Mayor?  
7 MR. MAYOR: Following through your thinking as  
8  
9  
10  
11  
12 THE CHAIRMAN: You can only answer this as a  
13 personal opinion rather than as an opinion from your Association.  
14 MR. MAYOR: I asked him as a citizen.  
15 THE CHAIRMAN: If you wish to answer it.  
16 MR. ATTORNEY: I think that would require  
17 considerable thought. I wouldn't want to answer that on a  
18  
19 THE CHAIRMAN: Any further questions? Mr. Simon.  
20 MR. SIMON: If the demand on the part of the  
21  
22  
23  
24  
25 MR. BAKER: I think this has had this effect as



1 One requires a much more effective visual system to operate in  
2 our society today successfully, and to compete successfully.  
3 I don't think this caused any problems, but if it has done so  
4 a lot of them have been masked simply because the demand has  
5 never been placed on the individual. When you consider our  
6 whole way of life, you barrel along the highway with a ton of  
7 steel under you, and have to read signs at a long distance, this  
8 is a far cry from the fellow who used to go along with his horse  
9 and cart and had all day to decide what to do. So in this  
10 sense certainly the importance of vision to the person in order  
11 to live and stay alive and compete in our society is much  
12 greater now.

13 I see it in my own family where I have two  
14 youngsters in public school in the early grades, and they have  
15 been forced to, because they don't do it voluntarily, they  
16 have been forced to read more books than I did in all the time  
17 I was in public school, so that constantly the demand is  
18 growing, and then for entertainment they watch T.V. all evening  
19 so that the fact of the matter is you are right. I agree and this  
20 is why we feel it is so important for them, for the children's  
21 well-being and more importantly to compete in our society even  
22 has become an extremely important sense.

23 THE CHAIRMAN: Mr. Caswell?

24 MR. CASWELL: There is just one question I  
25 would like to ask, and I am sure there is an answer to it. It



It would like to say, and I am sure there is no answer to it. It



1 does affect me just a little bit. You stated that an optician  
2 formerly had Grade XII and then one year training course and  
3 now he is trained, more or less, by correspondence and yet he  
4 is the man, I take it from you who in many many cases is the  
5 one who actually produces the glasses that you prescribe.

6 Now it seemed to me that this is terrifically  
7 important. That once the prescription has been made that it  
8 should be a very qualified person who fills this prescription.  
9 I am sure there is an answer but I am wondering with the  
10 limited amount of training evidently this optician has, how  
11 are we satisfied that we are getting the correct glasses?

12 MR. BAKER: I think that I added something here.  
13 First of all, I feel it was Grade XII and two years training,  
14 just to get the record straight. I think so. So far as  
15 training is concerned this would be a question which you should  
16 direct to the optician because he is much more familiar than I  
17 about training policy. One thing else that is involved, so far  
18 as the public is concerned and that is that it really is the  
19 ophthalmologist and the optometrist who assumes the responsi-  
20 bility that this is a correct device.

21 In our own office, whether we carry out the  
22 treatment service or have the treatment service provided by  
23 someone else, the patient comes back and is checked up. I  
24 believe that this is the custom of many ophthalmologists, so  
25 that in the last analysis the responsibility lies with the



1 I don't think we have a single file. You asked that an official  
2 testimony and that's all and then you were talking about the  
3 now he is trained, more or less, by correspondence and yet he  
4 in the way, I think it is from you that is very easy to see  
5 we are actually looking at the system that you described.  
6 Now it seemed to me that this is terrifically  
7 important. That is the investigation has been made that it  
8 should be a very detailed person and this is a prescription.  
9 I am sure there is an answer but I am worried with the  
10 system because we are talking with the system and the  
11 the we are talking about it and talking about it in a very  
12 MR. BAKER: I think that I added something here  
13 first of all, I think it was about XII and you were talking  
14 just to get the record straight. I think so. So far as  
15 training is concerned, this would be a question with the  
16 about the training policy. One thing else that is involved, so far  
17 as the public is concerned and that is that it really is the  
18 question of the system and the system is the system and the  
19 system is the system and the system is the system and the  
20 In our own office, whether we carry out the  
21 training or not, the training is the training and the  
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23 training is the training and the training is the training and the  
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1 prescriber.

2 MR. CASWELL: As you have said, the customer  
3 can still go in off the street to the optician and select a  
4 pair of glasses which he would put on and which he might read  
5 with very well at the moment.

6 THE CHAIRMAN: I don't think that is correct.

7 MR. BAKER: No.

8 MR. CASWELL: They do not sell to the customer?

9 MR. BAKER: No.

10 MR. BROAD: He will replace a broken lens sir.  
11 If you had a broken lens and went into his office, he could  
12 duplicate the broken lens or would phone the ophthalmologist  
13 or optometrist and get the prescription and fill it from that.

14 MR. CASWELL: You couldn't go in and buy a  
15 pair of glasses?

16 MR. BROAD: No.

17 THE CHAIRMAN: You used to be able to go into  
18 Woolworth's and buy glasses. What would prevent -- this is  
19 really aside from the issue here. This is more for my personal  
20 information, this question, than anything else but what would  
21 prevent an optician from selling glasses to a person who came  
22 in and decided what he wanted, just the same as the majority  
23 do in Woolworth's?

24 MR. BAKER: I think the answer to that is they  
25 are responsible people. They have integrity and they operate in



1  
2 MR. CASWELL: As you have said, the customer  
3 was willing to go to the trouble of having the  
4 pair of glasses made for him and was willing to  
5 with very well at the moment.  
6 THE CHAIRMAN: I don't think that is correct.  
7 MR. BAKER: No.  
8 MR. CASWELL: They do not sell to the customer?  
9 MR. BAKER: No.  
10 MR. BROAD: He will replace a broken lens etc.  
11 If you had a broken lens and went into his office, he could  
12 have the lens replaced for you. The optician  
13 at the time and the optician and that is the way  
14 MR. CASWELL: You couldn't go in and buy a  
15 pair of glasses?  
16 MR. BROAD: No.  
17 THE CHAIRMAN: You used to be able to go into  
18 Woolworth's and get glasses. That was the way it  
19 really came from the issue here. This is more for my personal  
20 information. I am not sure if it is correct or not.  
21 I am not sure if it is correct or not. I am not sure  
22 if it is correct or not. I am not sure if it is correct  
23 or in Woolworth's?  
24 MR. BAKER: I think the answer to that is they  
25 have been in the habit of doing so for some time.



1 a manner that most people would expect them to.

2 THE CHAIRMAN: This is a little more serious  
3 question. Assuming that an individual may go over to an  
4 ophthalmologist -- this is not an ophthalmologist versus an  
5 optometrist -- for refraction diagnosis that is included in  
6 the Act now, as far as the ophthalmologist or oculist is  
7 concerned, he could do that every year but we do not permit,  
8 under the Act as it is drawn up now, an annual or periodical health  
9 examination. Would you say that you could reconcile these  
10 two factors?

11 MR. BAKER: I am not sure that I understand this  
12 completely sir. Just let me ramble for a moment. I am not  
13 sure that we have any information as to the frequency at which  
14 refraction benefits may be utilized under this present Bill.

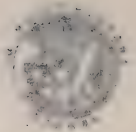
2 15 THE CHAIRMAN: As I interpreted the Bill there  
16 is no limitation. Is that right Mr. Whitney? In other words  
17 under the present Bill as it is drafted, an individual could  
18 go to an ophthalmologist for an eye examination every six months  
19 and he would still be eligible.

20 MR. WHITNEY: So far as I read it I think that  
21 is correct.

22 THE CHAIRMAN: Now can you reconcile the two?  
23 That we do not permit under the Bill as it is drafted here, an  
24 annual or periodical health examination.

25 MR. BAKER: I can only make an assumption Dr.





a number of people would expect them to.

THE CHAIRMAN: This is a little more serious

question, because that an individual may go over to an

opponent -- this is not an epidemiologic versus an

opponent -- the epidemiologic side is involved in

the fact, as far as the epidemiologic or scientific is

concerned, he will do that every year but we do not permit.

Under the Act as it is drawn up now, an annual or periodical

examination. Would you say that you could reconcile these

two factors?

MR. BAKER: I am not sure that I understand this

completely. Last year we had a number of cases. I am not

sure how we have the information as to the frequency at which

refraction occurs and we should under this present Bill.

THE CHAIRMAN: As I interpreted the Bill there

is no limitation. Is that right Mr. Whitby? In other words

under the present Bill as it is drafted, an individual could

go to an optician for an eye examination every six months

and he would still be eligible.

MR. WHITBY: So far as I read it I think that

is correct.

THE CHAIRMAN: Now can you reconcile the two?

That we do not permit under the Bill as it is drafted now, an

annual or periodical refraction examination.

MR. BAKER: I can only make an assumption Dr.



1 Hagey here. I would have imagined that that particular matter  
2 would have been taken care of under the regulations in the sense  
3 of how frequently a particular benefit might be utilized. As  
4 I say, I was impressed with the -- I read the transcript of  
5 the hearing at Windsor, and I was impressed with this gentle-  
6 man's statement when you have a first call involved, which you  
7 apparently do under this Bill, how you are going to distinguish  
8 between that and annual inspection. This struck me as being  
9 a very difficult thing.

10 MR. WHITNEY: That is a real problem.

11 THE CHAIRMAN: If refractions are permitted to  
12 remain in the Bill, and again regardless of whether this is  
13 done by an ophthalmologist or an optometrist, would it be just  
14 as logical that there be a limitation put on it?

15 MR. ATTRIDGE: Yes.

16 THE CHAIRMAN: What limitation would you suggest?

17 MR. ATTRIDGE: Two years.

18 THE CHAIRMAN: Every two years?

19 MR. ATTRIDGE: Yes.

20 THE CHAIRMAN: I assume that the cost of the  
21 glasses, aside from the examination for them, is approximately  
22 the same regardless of whether they are prescribed by an  
23 optometrist or an ophthalmologist. Is that correct?

24 MR. ATTRIDGE: There should not be any difference.

25 THE CHAIRMAN: Not any wide variation?



...I would have thought that that particular ...  
...I would have thought that that particular ...  
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MR. WHITNEY: That is a real problem.

THE CHAIRMAN: If limitations are put on it ...  
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MR. ATTRIDGE: ...  
THE CHAIRMAN: What limitation would you suggest ...  
MR. ATTRIDGE: Two years ...  
THE CHAIRMAN: Every two years?

MR. ATTRIDGE: ...  
THE CHAIRMAN: I assume that the cost of the ...  
...I would have thought that that particular ...  
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...I would have thought that that particular ...

MR. ATTRIDGE: There should not be any difference ...  
THE CHAIRMAN: Not any wide variations?





1 MR. ATTRIDGE: The laboratory costs plus the  
2 extra services that are entailed.

3 THE CHAIRMAN: What would be your opinion as to  
4 the average cost of a pair of glasses? Now I realize that they  
5 can vary. From how much to how much?

6 MR. ATTRIDGE: Such a great variation depending  
7 on what is involved. It reminds me of someone said how many  
8 prescriptions can you write and I just read an article recently  
9 where it indicated, it showed figures that there is something  
10 more than two or three trillion. Of course, you see that  
11 involves a great deal of variation in the expense and again  
12 if a person wants to use them, can use a very cheap, a very  
13 inexpensive frame or they can, if they want, go into an  
14 elaborate frame.

15 THE CHAIRMAN: I am thinking primarily of a  
16 person who has difficulty in financing the cost of glasses.  
17 So assuming that this individual would be inclined to use the  
18 most economical frame available, would the average cost for the  
19 glasses be in the neighbourhood of \$12.00? \$20.00?

20 MR. ATTRIDGE: I am not hedging but are you  
21 talking about single vision? Are you talking about bifocles?  
22 Are you talking about trifocles?

23 THE CHAIRMAN: I am trying to strike an average  
24 across the board. I will tell you exactly what I am leading  
25 up to in this question. I am not trying to catch you on anything.



MR. ATTRIDGE: The laboratory costs plus the

extra services that are entailed.

THE CHAIRMAN: What would be your opinion as to

the average cost of a pair of glasses? Would you realize that they

can vary. From how much to how much?

MR. ATTRIDGE: There is great variation depending

on what is involved. It varies as to whether you have

prescription or not, and I just want to state that

even if you have a pair of glasses, there is something

more than just the cost of the glasses. You see that

there is a great deal of variation in the expense and again

it is a matter of the type of lens, and the type of

expensive frame or they can, if they want, go into an

elastic frame.

THE CHAIRMAN: I am thinking primarily of a

person who has difficulty in financing the cost of glasses.

It is assumed that this individual would be looking for the

most economical frame available, would he not?

Glasses he in the neighborhood of \$12.00? \$20.00?

MR. ATTRIDGE: I am not hedging but are you

referring to elastic frames? Are you talking about elastic

Are you talking about trifocals?

THE CHAIRMAN: I am trying to state an average

figure, but I will tell you exactly what I am feeling

up to in this question, I am not trying to catch you on any



1 MR. ATTRIDGE: No, I know.

2 THE CHAIRMAN: And that is that in my humble  
3 opinion the hardship involved for the individual is not the  
4 original \$10.00. Am I right in that?

5 MR. BAKER: Part of it.

6 THE CHAIRMAN: The cost of the glasses is a  
7 greater financial hardship than the cost of the examination.

8 MR. ATTRIDGE: It depends. I do not think it  
9 should be in most cases. Now admittedly you won't get much  
10 lab work done for \$10.00.

11 THE CHAIRMAN: That is what I mean.

12 MR. ATTRIDGE: It would be more than \$10.00 in  
13 most cases.

14 THE CHAIRMAN: I do not recall getting a pair  
15 of glasses myself, even right from the very beginning for less  
16 than \$10.00.

17 MR. ATTRIDGE: It would be, in most cases, more  
18 than \$10.00.

19 MR. BAKER: I think this opens up a whole area  
20 for discussion. Doesn't the same attitude prevail here in  
21 terms of saying well if you are going to provide medical service,  
22 which this Bill does, it really doesn't provide any treatment  
23 service, other than the surgical ones, and it seems to me that  
24 one could carry this same argument along and say well what has  
25 cost more, the medical service or the pharmaceutical devices





MR. ATTRIDGE: No, I know.

THE CHAIRMAN: And that is that in my humble

opinion the hardest thing for an individual is not the

original \$10.00. Am I right in that?

MR. BAKER: Part of it.

THE CHAIRMAN: The cost of the glasses is a

greater financial burden than the cost of the examination.

MR. ATTRIDGE: It depends. I do not think it

should be in most cases. Now, naturally you won't get much

lab work done for \$10.00.

THE CHAIRMAN: That is what I mean.

MR. ATTRIDGE: It would be more than \$10.00 in

most cases.

THE CHAIRMAN: I do not recall getting a pair

of glasses myself, even right from the very beginning of the

then \$10.00.

MR. ATTRIDGE: It would be, in most cases, more

than \$10.00.

MR. BAKER: I think that opens up a whole area

for discussion. I don't think the responsibility should be in

terms of saying well, if you are going to provide medical service

which costs \$10.00, it really doesn't provide any treatment

service, other than the original cost, and it seems to me that

one would carry that cost along and say well, that's

not good, but medical service is the pharmaceutical device



1 that are required in order to treat it. It's in the same realm.

2 THE CHAIRMAN: I am not debating the issue.

3 I am looking for information for the record. Are there any  
4 other questions?

5 MRS. AYLEN: I have one very short one. Does  
6 your profession take part in any research projects in relation  
7 to diseases of the eye or eye problems shall I say?

8 MR. BAKER: If you mean by "our profession"  
9 the profession generally, the answer is very definitely yes.  
10 Most of our research in this field has been done in the United  
11 States and is being done in the United States and most of it  
12 is being done in the University Schools in the United States  
13 and they have been involved very deeply with the Armed Forces,  
14 and so forth, and their grants are quite astronomical. We have  
15 done some limited research at our own College here. We are  
16 doing more and if we can find the answer to finances, we will  
17 do even more but generally speaking optometry has made a very  
18 significant contribution to ophthalmologic literature here and  
19 in the United Kingdom and so forth, Australia.

20 MRS. AYLEN: Do you ever take part in any out-  
21 patient clinics in the hospitals?

22 MR. BAKER: We would like to. I think the answer  
23 to that is that we would like to. There is some activity but  
24 it is limited. We would like to do more. We do operate a  
25 clinic here, you know. It is not a joint clinic at all.



1 that are recorded in order to have it. I do not think it is

2 THE CHAIRMAN: I am not debating the issue.

3 I am looking for information for the record. Are there any

4 other questions?

5 MRS. AYLEN: I have one very short one. Does

6 your profession have any in any research program in relation

7 to diseases of the eye or the eye in general? I beg

8 MR. BAKER: If you mean by "our profession"

9 the profession generally, the answer is very definitely yes.

10 Most of our research in this field has been done in the United

11 States and is being done in the United States and some of it

12 is being done in the Governmental Laboratory in the United States

13 and they have been interested very deeply with the armed forces,

14 and so forth, and their interest is quite substantial. We have

15 some very limited interest as our own College has. We are

16 doing work and if we did this kind of research, we will

17 do even more and generally speaking, especially now since a very

18 substantial contribution to ophthalmologic literature has been

19 in the United Kingdom and so forth, Australia.

20 MRS. AYLEN: Do you ever take part in any out-

21 patient clinics in the hospitals?

22 MR. BAKER: We would like to. I think the answer

23 is that we would like to. There is some activity in

24 it is limited. We would like to do more. We do operate a

25 clinic every year. It is not a large clinic at all.





1 THE CHAIRMAN: Any further questions?

2 MR. MAJOR: I wonder if I could clarify one  
3 point that keeps coming back to my mind and that is this 2,600  
4 people that were handled. 2,600 indigents. Was that on a  
5 special arrangement?

6 MR. LANGER: This is not any special arrangement  
7 at all sir. The 2,600 indigents that I referred to are the  
8 numbers, the approximately numbers in any given year who  
9 received direct Provincial assistance and obtained vision care.  
10 I cannot tell you any breakdown as to who was provided care, but  
11 this is the number that the Department of Welfare has indicated  
12 to us.

13 MR. MAJOR: I understand. In other words, this  
14 is not 2,600 persons treated by optometrists or ophthalmologists.  
15 This is the whole works?

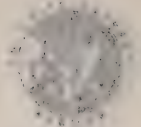
16 MR. LANGER: Yes.

17 MR. MAJOR: In other words, does this intimate  
18 that the 230,000 people on the medical welfare plan do not get  
19 eye care except on a special arrangement of either one or the  
20 other?

21 MR. LANGER: That is correct.

22 THE CHAIRMAN: Do you have any further statements  
23 Mr. Attridge?

24 MR. ATTRIDGE: Yes. I think Mr. Broad has a  
25 statement.



THE CHAIRMAN: The hon. member for—

MR. MAJOR: I wonder if I could clarify one

point that might come out of my mind and read the last of it.

People that were sent to the hospital, but not to a

special arrangement?

MR. LANGER: This is not any special arrangement

at all. The 4,000 patients that I referred to are the

patients, the approximately number is not given any

special treatment, treatment and special treatment

I cannot tell you any breakdown as to who was provided care, but

that is the number that was provided care, and that is the

to me.

MR. MAJOR: I understand. In other words, this

is not 2,000 patients treated by optometrists or optometrists

This is the whole work?

MR. LANGER: Yes.

MR. MAJOR: In other words, does this include

that the 230,000 people on the medical welfare plan do not get

any special treatment or special treatment? Is that correct?

Others?

MR. LANGER: That is correct.

THE CHAIRMAN: Do you have any further statement

to make?

MR. MAJOR: Yes, I have one more and a

statement.



1 MR. BROAD: Dr. Hagey, ladies and gentlemen, if  
2 I may be permitted with your permission to make a closing  
3 statement, I would like to thank you very much for your  
4 questions and I hope that you understand that we answered them  
5 with sincerity and as factually as we possibly could.

6 However, the problem, as we see it, Bill 163  
7 does violate what we consider to be certain basic principles.  
8 First: That legally qualified optometrists are excluded from  
9 performing vision service included in Bill 163. And secondly,  
10 the right of the public to free choice of practitioner has  
11 been denied. Thirdly, there has been no discussion with the  
12 optometrical profession whose service forms a part of the  
13 enactment of this nature. There is, we feel, a simple way of  
14 resolving this problem: Include optometry the way division  
15 services are included in the Act and permit us to assist in  
16 preparing that portion of the Act where our services are  
17 designated.

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MR. BROAD: Dr. Hagey, ladies and gentlemen, I

I am very pleased to participate in this discussion.

statement, I would like to thank you very much for your

questions and I hope that you understand that we answered them

with sincerity and as factually as we possibly could.

However, the problem, as we see it, Bill 163

is a very complex one and it is not possible to discuss it in a few minutes.

There are three main points involved in this problem.

performing vision service included in Bill 163. And secondly

the right of the public to free choice of practitioner has

been denied. Thirdly, there has been no discussion with the

optometrical profession whose services form a part of the

enactment of this nature. There is, we feel, a simple way of

resolving this problem: Include optometry in the way division

services are included in the Act and permit us to assist in

preparing that portion of the Act where our services are



T/hm

1 MR. BROAD: May we take this opportunity of  
2 impressing on you again the sincerity of our presentation and  
3 let me assure this Committee that the Ontario Optometric  
4 Association and the College of Optometrists have a sincere  
5 desire to co-operate with the Committee, the government and  
6 any or all professions in the health care field in order that  
7 the people of Ontario may receive the finest form of health  
8 care service.

9 Our offices are at your disposal to assist you  
10 in any way we possibly can. We are aware, as all must be, of  
11 the magnitude of your task before you. We wish you well in  
12 your deliberations. We are certain that this Committee will  
13 arrive at a final recommendation that will be acceptable to all  
14 and in the best interest of the people of the Province of  
15 Ontario.

16 Thank you, ladies and gentlemen.

17 MR. MULROONEY: I think these gentlemen should  
18 be commended for their presentation of the case.

19 DR. BUTT: In view of your final statement, I  
20 believe you have carried on some negotiations with co-ops.

21 MR. BROAD: Yes.

22 DR. BUTT: We would be most interested in  
23 receiving from you all the details of this which might be  
24 further useful to us.

25 MR. BROAD: We will certainly see that you get it.



MR. BROAD: May we take this opportunity of

representing our view regarding the situation of the Province of Ontario and the health of the people of Ontario may receive the finest form of health care service.

Our offices are at your disposal to assist you in any way we possibly can. We are aware, as all must be, of the magnitude of your task before you. We wish you well in the Province of Ontario and in the best interest of the people of the Province of Ontario.

Thank you, ladies and gentlemen.

MR. MURROONEY: I think these gentlemen should be commended for their presentation of the case.

DR. BUTT: In view of your final statement, I believe you have carried on some negotiations with co-ops.

MR. BROAD: Yes.

DR. BUTT: We would be most interested in receiving from you all the details of this which might be further useful to us.

MR. BROAD: We will certainly see that you get





1 THE CHAIRMAN: It is the desire of this Committee  
2 to obtain all information we can that will help us with our  
3 assignment. I wished we shared your confidence in our ability  
4 to come up with the best plan satisfactory to everybody.

5 Thank you very much.

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SUBMISSION OF

DR. J. W. MCGILLIVRAY

THE CHAIRMAN: I assume you are Dr. McGillivray?

DR. MCGILLIVRAY: Yes.

THE CHAIRMAN: Did you read the statement of instructions? If not, we will allow you to read it.

DR. MCGILLIVRAY: I have.

THE CHAIRMAN: Do you wish to proceed?

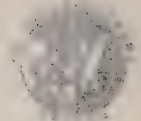
DR. MCGILLIVRAY: Mr. Chairman, I made suggestion of this presentation not as a representative of any organization but representing certain ideas which are old ideas held by many people, many of them dead, perhaps most of them dead now. That is the idea that the individual of this society is fully capable of making his own decisions rather than having his decision of health matters made for him in such a role with such a group of people.

Would you like me to read my short submission?

THE CHAIRMAN: As stated in the instruction, the members of the Enquiry have read your brief. You can emphasize any part of it or supplement what you wish. I hope you will not attempt to read the whole book.

DR. MCGILLIVRAY: I will not. I think I would prefer -- I have certain ideas which may be perhaps better shown up if there are any questions which you would consider.





DR. J. W. McGILLIVRAY

THE CHAIRMAN: I assume you are Dr. McGillivray.

DR. McGILLIVRAY: Yes.

THE CHAIRMAN: Did you read the statement of

instructions? If not, we will allow you to read it.

DR. McGILLIVRAY: I have.

THE CHAIRMAN: Do you wish to proceed?

DR. McGILLIVRAY: Mr. Chairman, I made a suggestion

of this presentation not as a representative of any organization

but as a representative of the people of this country.

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fully capable of making his own decisions rather than having

his decision of health matters made for him in such a role

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Would you like me to read my short submission?

THE CHAIRMAN: As stated in the instructions,

the members of the Society have read your brief. You can

emphasize any part of it or supplement what you wish. I hope

you will not attempt to read the whole book.

DR. McGILLIVRAY: I will not. I think I would

like to have certain things said and to discuss them

some of it there are any questions with you, please



1 If there are no questions, then of course you do not wish to  
2 consider my idea at all.

3 Basically my idea is, if poor people need money  
4 they should be given money; and they are fully capable of  
5 voting and fully capable of fighting and dying for their  
6 country and fully capable of drinking beer in a beer parlour  
7 or buying liquor in a liquor store and capable of spending their  
8 own money for health insurance if given the opportunity.

9 Some of them, if they have no money, may need  
10 money. This is something that the government should decide,  
11 that the poor who need money should be given money.

12 As my Appendix A states, this may be made  
13 exceedingly easy for them to buy health insurance if they wish.  
14 The net result of putting the money in the hands of the people,  
15 and I am not a supporter of the Social Credit Party, is that  
16 the people can decide what type of insurance they wish.

17 We have just heard that the optometrists wish to  
18 be included. Oral surgeons also wish to be included. The  
19 chiropractor also. As you will see in my paragraph 5 sub-  
20 paragraph 5, and as I noted in the press, the Christian  
21 Scientists feel they were paying tax to support a medical  
22 system in which they do not believe. I submit this is unfair,  
23 taxing the Christian Scientists to support another church in  
24 which they do not believe.

25 If the oral surgeons and chiropractors and







1 physiotherapists wish to be included in this, the government  
2 I suspect cannot afford to pay for it. If they go before a  
3 limited group that Bill 163 is supposed to cover and if my  
4 suspicion and many other people's suspicions prove correct,  
5 this is going to be extended to include the whole population.

6 Then the government is going to either legislate  
7 in or legislate out certain groups. In other words, they will  
8 water the pot plant of organized medicine and they will leave  
9 the pot plant of optometrists, chiropractors, Christian  
10 Science, oral surgeons, to go dry, because the government  
11 is the largest controller of the funds which would come into  
12 these various places, health professions if you care to use that  
13 term.

14 I would honestly think there may be some poor  
15 people who are poor and who might not buy health insurance. We  
16 should accept the fact that they should be given the opportunity  
17 to buy it as they see fit. If they see fit not to buy it,  
18 this is their responsibility. They probably think they do not  
19 need it.

20 I would hope that the Committee would not feel  
21 that the government had to mind everybody's business and compel  
22 all the poor people of the province to have the type of plan  
23 the Committee thinks is best. I see no other way around this  
24 except start letting these poor people buy what they wish.

25 THE CHAIRMAN: I hope you gathered from the



1 I suspect cannot afford to pay for it. If they go before a  
2 legislative body, it is essential to have some  
3 legislation and that is why I am going to have some  
4 legislation. Then the government is going to either legislate  
5 or to legislate by means of the courts. In either case, they will  
6 water the pot plant of organized medicine and they will leave  
7 the pot plant of optometrists, chiropractors, Christian  
8 Science and various other sects. I am going to have some  
9 legislation to take care of these various places, health professions if you care to use the  
10 term.  
11 I would honestly think there may be some poor  
12 people who are poor and who might not buy health insurance. I  
13 should accept the fact that they should be given the opportunity  
14 to buy it as they see fit. If they see fit not to buy it,  
15 this is their responsibility. They probably think they do not  
16 need it.  
17 I would hope that the Committee would not feel  
18 that the government has to take responsibility for all these people  
19 all the poor people of the province to have the type of plan  
20 that I am talking about. I see no reason why they should have  
21 except their health. These poor people pay what they can.

THE CHAIRMAN: I hope you gathered from the



1 instructions that it is not the intention of the Enquiry to  
2 debate any issues.

3 We do ask questions where we feel there is need  
4 for clarification. I think that your point is a very simple  
5 and forward point.

6 Are there any members of the Enquiry who have  
7 questions to ask?

8 MRS. AYLEN: I notice you are Dr. J. W.  
9 McGillivray? What are you a doctor of?

10 DR. MCGILLIVRAY: I am a practising surgeon.

11 MRS. AYLEN: In what town?

12 DR. MCGILLIVRAY: Collingwood.

13 MRS. AYLEN: You say you think the people should  
14 be given the money to spend as they see fit. Do you have any  
15 reason to believe they would spend it on paying doctor bills  
16 as opposed to buying a case of beer?

17 DR. MCGILLIVRAY: I knew someone would raise that  
18 question and I am glad you did.

19 If they would rather buy a case of beer with  
20 their five dollars a month, it is because they do not parti-  
21 cularly want medical insurance. If this is so, then I submit  
22 it is beyond the proper limits of the government to insist they  
23 have medical insurance. The reason they would be given this  
24 money is according to the philosophy that gathers momentum  
25 behind the medical push. These people -- social justice demands





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 2 debate any issues.  
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 21 larly want medical insurance. If this is so, then I submit  
 22 it is beyond the proper limits of the government to insist that  
 23 they should pay for medical insurance.



1 that they be given more money or they are receiving insufficient  
2 of society's goods and services.

3 If they buy a case of beer, they apparently do  
4 not wish to have medical insurance which means less push for  
5 medical insurance.

6 MRS. AYLEN: Is it fair to ask you, do you have  
7 any bills you cannot collect?

8 DR. MCGILLIVRAY: Yes, quite a few.

9 MRS. AYLEN: You do not mind that?

10 DR. MCGILLIVRAY: I like to collect them.

11 MRS. AYLEN: You would just as soon they buy  
12 a case of beer?

13 DR. MCGILLIVRAY: No, buy insurance. If they  
14 cannot be free to spend their social justice money, then neither  
15 can I.

16 MRS. AYLEN: The expression "second-class  
17 citizens" seems to be coming up quite often. What is your  
18 definition of a second-class citizen?

19 DR. MCGILLIVRAY: The rules of this Enquiry are  
20 that there shall be no second-class citizens which means it is  
21 assumed that there are in Ontario no second-class citizens,  
22 which means the poor who want medical insurance would buy  
23 medical insurance if they had the money is what I am suggesting.

24 THE CHAIRMAN: Are there any other members who  
25 wish to ask questions?



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DR. MCGILLIVRAY: The rules of this Inquiry are that there shall be no second-class citizens which means it is assumed that there are in Ontario no second-class citizens, which means the poor who want medical insurance would pay medical insurance if they had the money is what I am suggesting.

THE CHAIRMAN: Are there any other members who wish to ask questions?





1 MR. CASWELL: Should they not be given \$10.00  
2 a month so they can buy both beer and insurance?

3 DR. MCGILLIVRAY: With the rate of taxation, if  
4 they spend it on hard liquor it would cost us dollars worth of  
5 taxes.

6 MR. WHITNEY: This freedom of social justice  
7 money, tell me where it comes from and what it means.

8 DR. MCGILLIVRAY: It is the composite poor, the  
9 idea that our poor are poor through no fault of their own but  
10 because they have been a victim of misfortune or ill done by  
11 by a sharp business man, and from the rest of society they need  
12 help and that help has taken the form of family allowance and  
13 old age pension, and now it is being suggested that it take  
14 the form of the medical care insurance act. We do not give  
15 them food and clothing. We give old age pensioners, we give  
16 them money and I am suggesting we pay them approximately \$75.00  
17 a month for the amount for their insurance money for the year --  
18 their thirteenth month if you like. This is what I mean by  
19 social justice. It is a Robin Hood system which has apparently  
20 been accepted.

21 MR. WHITNEY: The essence of your suggestion is  
22 that you are suggesting to the Enquiry that we consider in our  
23 recommendations to the government that government tax everyone  
24 in Ontario, gather into the fund this taxation money and then  
25 send out cheques?

DR. MCGILLIVRAY: With the rate of taxation,

MR. WHITNEY: This freedom of social justice

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them food and clothing. We give old age pensioners, we give

I photographically copy each set of drawings and I have always found

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THE UNIVERSITY OF CHICAGO

Page 240 of 240

been accepted.

MR. WHITNEY: The essence of your suggestion

that you are suggesting to the Industry that we consider in

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

IN OBSERVING THE PRESENT STATE OF THE

send out orders?



1 DR. MCGILLIVRAY: This is certainly what I am  
2 suggesting.

3 MR. WHITNEY: I think that is all I have, Mr.  
4 Chairman.

5 THE CHAIRMAN: Mr. Naylor?

6 MR. NAYLOR: This is a very interesting proposal  
7 and personally I am all in favour of your idea of having large  
8 freedom of choice for the individual as possible and as little  
9 government compulsion as possible.

10 There is one point that possibly should be  
11 qualified. Your brief suggests your plan to help involves  
12 the government purchasing, making the government the largest  
13 single purchaser of insurance in the province. That is not  
14 what is proposed.

15 What is proposed is that individuals may purchase  
16 insurance and if they do and if they are in a certain income  
17 category the government will help them to pay premiums. There  
18 is no compulsion of paying insurance. So that the difference  
19 between your idea and the idea of the Bill seems to be merely  
20 that the person is not given the financial assistance unless he  
21 actually decides to buy insurance.

22 DR. MCGILLIVRAY: He can take it or leave it.

23 MR. NAYLOR: That is right.

24 DR. MCGILLIVRAY: Can take what the government  
25 thinks is good for him or he can have nothing at all.





DR. MCGILLIVRAY: This is certainly what I am

suggesting.

MR. WHITNEY: I think that is all I have, Mr.

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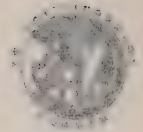


1 MR. NAYLOR: No. This plan, standard plan as  
2 it might be called, that is laid down by the Bill is to be made  
3 available. Carriers can and will offer other kinds of insurance  
4 with lesser or greater benefits.

5 DR. MCGILLIVRAY: And totally subsidized, and  
6 they will be able to choose which carrier and which type of  
7 plan they wish.

8 MR. NAYLOR: No. Subsidy will only be available  
9 on the standard plan, and that is the point.

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MR. NAYLOR: No. This plan, standard plan as  
it is called, that is the plan of the Bill as it is  
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1 MR. NAYLOR: You still think that additional  
2 staff is desirable to give responsibility, ~~to give the lower income~~  
3 classes the money regardless of whether they buy insurance or  
4 not?

5 DR. MCGILLIVRAY: If the concept underlying this  
6 is the concept of social justice and if these people are com-  
7 petent to vote then I would suggest they are competent to  
8 decide what insurance they want. ~~They'd get further credit if they~~  
9 had a fire or automobile accident. That is certainly a very  
10 big point, an automobile accident without automobile insurance,  
11 I mean collision insurance as well as liability insurance.  
12 He could be far more financially crippled by lacking one of  
13 these other insurances than lacking medical insurance. It  
14 might be that the individual thinking citizen, would be buyer  
15 or not, would be better off to buy a different kind of  
16 insurance or simply buy clothes for his children, put shoes  
17 on their feet. He may be perfectly happy living in Toronto  
18 getting his optometrical from the Optometry College which I  
19 did when I was a student, his dental from the College of  
20 Dentistry, which I did as a student and his medical from the  
21 health services or the out-patient departments, from the out-  
22 patient departments of the Western Hospital, Sick Children's.  
23 He might be better off to do that and spend his money on his  
24 rent.

25 MR. NAYLOR: Suppose he lives in Collingwood and

DR. MCDONALD: It is the concept underlying the

and a line of automobile accident. That is certainly a very

I have collected papers as well as possible.

single other persons than listed medical personnel. It

to have something to say in the matter of the

on their feet. He was the perfectly happy living in Toronto

did when I was a student, his dental from the College of

Dentistry, which I did as a student and his medical from the  
could achieve in the medical field, from the

He might be helped, if he had and spent his money on his

MR. NAYLOR: Suppose he lives in Collingwood St.



1 gets money from the government and decides not to buy the  
2 insurance hoping he will be lucky and not have any heavy  
3 expense. If he does have heavy medical expenses he would have  
4 to go to a doctor such as yourself for it.

5 DR. MCGILLIVRAY: Yes.

6 MR. NAYLOR: Wouldn't you recommend he had the  
7 insurance?

8 DR. MCGILLIVRAY: I would be sorry if he didn't.

9 MR. NAYLOR: You would still be willing to  
10 provide the service?

11 DR. MCGILLIVRAY: The most crippling expense,  
12 heavy medical expense, would still be the hospital bills. We  
13 still have patients that don't have hospital insurance. I  
14 don't send a bill. If they haven't got enough money to buy  
15 hospital insurance there is no money left for me and I don't  
16 worry about it. I wouldn't like that to get around.

17 MR. SIMON: You are unique.

18 DR. MCGILLIVRAY: Sir, I think there are a lot  
19 like me. You can't get blood out of a stone. For the people  
20 without insurance you don't waste your stamps trying to  
21 collect the money.

22 MR. SIMON: Wouldn't you rather see they did  
23 have insurance?

24 DR. MCGILLIVRAY: That would be fine. There is  
25 the other thing, that is if they are going to be compelled to





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4 to go to a doctor such as yourself for it.  
5 DR. MCGILLIVRAY: Yes.  
6 MR. NAYLOR: Wouldn't you recommend he had the  
7 insurance?  
8 DR. MCGILLIVRAY: I would be sorry if he didn't.  
9 MR. NAYLOR: You would still be willing to  
10 provide the service?  
11 DR. MCGILLIVRAY: The most crippling expense,  
12 many medical expenses, would still be the crippling expense.  
13 I still have a feeling that they have a right to it.  
14 don't send a bill. If they haven't got enough money to pay  
15 hospital insurance there is no money left for me and I don't  
16 worry about it. I wouldn't like that to get around.  
17 MR. SIMON: You are unique.  
18 DR. MCGILLIVRAY: Sir, I think there are a lot  
19 of people like you around here and in a hospital. You are a  
20 different kind of person. You are a different kind of person.  
21 collect the money.  
22 MR. SIMON: Wouldn't you rather see they did  
23 have insurance?  
24 DR. MCGILLIVRAY: That would be fine. There is  
25 no more thing than to see they have insurance.



1 have insurance, the long and short of it is that the medical  
2 fees and the optometrist fees and the dental fees and the  
3 pharmacist fees, once these are included, assuming that it is,  
4 they will be compelled by the government which may have a  
5 deadening effect. That is the reason why I would rather do  
6 without the odd money from my poor indigent patients and main-  
7 tain my control and theirs.

8 MR. CASWELL: Some people have to be taken care  
9 of, they always have and they always will and this is one way  
10 of doing it.

11 DR. MCGILLIVRAY: The profession, if I may speak  
12 briefly of the profession, has always looked after these  
13 people and will always care for them. They cared for them  
14 before there was any medical insurance at all. I am not  
15 suggesting they wouldn't get medical care. I am suggesting  
16 we would all be better off if we weren't compelled to have  
17 medical insurance under the government's terms.

18 MR. CASWELL: Is there a reasonable reason why  
19 one group of citizens in the province should carry this  
20 responsibility? You are suggesting it is the responsibility  
21 of the medical association to take care of this. The govern-  
22 ment would suggest it is the responsibility of all the citizens  
23 of the Province of Ontario.

24 DR. MCGILLIVRAY: If I may, Mr. Chairman, I  
25 should say the medical profession has never objected to this



1 have mentioned the fact that out of the 100,000  
2 men and the 100,000 women and the 100,000 children  
3 (approximately) who are in the province, only 10,000  
4 are employed by the Government which is not a  
5 satisfactory figure. There is the reason why I would rather  
6 rather have the Government employ more people than  
7 have my control and theirs.

8 MR. GARDNER: Some people have to be taken care  
9 of, they are the poor and the sick and the old and  
10 of being so.

11 DR. McLELLIN: The profession, if I may say  
12 that, the profession, the people, the people, the  
13 people and the people and the people, they are the  
14 before there was any medical insurance at all. I am not  
15 suggesting that the medical profession is the only  
16 we would all be better off if we weren't compelled to have  
17 medical insurance under the Government's terms.

18 MR. GARDNER: In fact, a Government should  
19 one group of citizens in the province should carry this  
20 responsibility. The Government is the one responsible  
21 for the health of the people and the people, the Govern-  
22 ment should be responsible for the health of all the citizens  
23 of the Province of Ontario.

24 DR. McLELLIN: If I may, Mr. Chairman, I  
25 should say that the medical profession is not responsible for





1 responsibility. Objections have come from social workers and  
2 various other people who want to do good for the poor people.  
3 The doctors have never objected to this as a group, and very  
4 few of them individually. I should suggest that the doctors  
5 are willing to have this medical insurance grow as it grows,  
6 but the government would be taking a hand, a controlling hand.

7 THE CHAIRMAN: Dr. Galloway.

8 DR. GALLOWAY: My question has already been  
9 asked and answered.

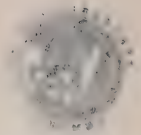
10 THE CHAIRMAN: Any further questions?

11 MR. SIMON: If we draw the conclusion to the  
12 logical end the government should not interfere with parents  
13 having three children, eight, ten and twelve, not sending them  
14 to school but sending them to work. Is that all right with  
15 you?

16 DR. MCGILLIVRAY: I haven't entered into the  
17 education problem at all.

18 MR. SIMON: It is the same thing. If the  
19 citizen is made to choose whether he is going to have insurance  
20 he is going to send his children to school or send them to  
21 work -- he is choosing a lot of things. Is there to be no  
22 government intervention?

23 DR. MCGILLIVRAY: May I take this further:  
24 Supposing you follow this further and people who have medical  
25 insurance that have to have an operation, have to have an



responsibility. Objections have come from social workers and  
various other people who want to do good for the poor people.  
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DR. GALLOWAY: My question has already been  
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work -- he is choosing a lot of things. Is there to be no  
government intervention?

DR. MCGILLIVRAY: May I take this further:  
The government has the right to say to people who are not  
insured that they must have insurance.



1 operation or blood transfusion. Are you going to compel them  
2 to do that because a legally qualified medical practitioner  
3 says you must have this operation? Is Government going to  
4 take that responsibility for an adult, not just for children?  
5 When you are compelled to have medical insurance should you  
6 be compelled to accept the medical treatment that is advised  
7 to you because a qualified person is telling you?

8 MR. SIMON: Bill 163 doesn't say anybody is  
9 compelled to have medical care. The government will pay for  
10 people that want insurance and can't afford to pay for it  
11 themselves. There is a difference in that.

12 THE CHAIRMAN: I think, Dr. McGillivray, you are  
13 presenting a philosophy almost of ~~life~~ here, which is a tempta-  
14 tion to debate. I think some of the members of the Enquiry  
15 are yielding to that temptation. I must admit I am having  
16 trouble not doing it myself, but that isn't our job here today.  
17 It is a temptation, I'll grant you that. I don't think we  
18 should yield to that temptation here any more than we have  
19 with other delegations we have heard. We do want to ask  
20 questions and seek for clarification and I don't want to stop  
21 that at all.

22 DR. BUTT: Could I add one thing. I took the  
23 liberty of asking a question yesterday of a social worker and  
24 I have a quote from her. I asked her about your proposition  
25 and she said that I would certainly think social workers would





to you because a qualified person is telling you?

MR. SIMON: Bill 163 doesn't say anybody is

compelled to have medical care. The government will pay for

people that want insurance and can't afford to pay for it

themselves. There is a difference in that.

THE CHAIRMAN: I think, Dr. McGillivray, you are

presenting a bill that is a very

tion to debate. I think some of the members of the Ministry

are not in that position. I want to say that

is a temptation, I'll grant you that. I don't think we

with other delegations we have heard. We do want to ask

questions and seek for clarification and I don't want to stop

that at all.

DR. BUTT: Could I add one thing. I took the

time of asking a question yesterday for a social worker and

I have a question for you. I want to know your opinion

and also that I would like to know what you would



1 support the idea that the person has the right to decide how  
2 he is going to spend his money himself and that it is his  
3 responsibility to do it." In all fairness to the rest she said  
4 "I would say it is ~~one~~ possible way. I wouldn't say I would  
5 support it". That is the social worker's answer. I think in  
6 fairness that there are two sides to the coin. I believe you  
7 feel it is the same thing as the baby bonus?

8 DR. MCGILLIVRAY: Mr. Chairman, may I ask one  
9 question: If a citizen is not fit to decide whether or not he  
10 will have insurance and how he will use his Social Justice  
11 Money, if I may use my term, is he fit to vote? I am not  
12 asking anybody to answer that, but I think the Committee should  
13 consider this.

14 THE CHAIRMAN: Any further questions? Do you  
15 have any further statement, Doctor?

16 DR. MCGILLIVRAY: No, sir.

17 THE CHAIRMAN: Thank you very much.

18

19 ---Whereupon the hearing was adjourned until 10:00 a.m.,  
20 Tuesday, 21st January, 1964.

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25





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2 he is going to spend his money himself and that it is his  
3 responsibility to do it." In all fairness to the rest of the  
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12 asking anybody to answer that, but I think the Committee should  
13 consider this.

14 THE CHAIRMAN: Any further questions? Do you  
15 have any further statement, Doctor?

16 DR. McGILLIVRAY: No, sir.

17 THE CHAIRMAN: Thank you very much.

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19 --Whereupon the hearing was adjourned until 10:00 a.m.,  
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